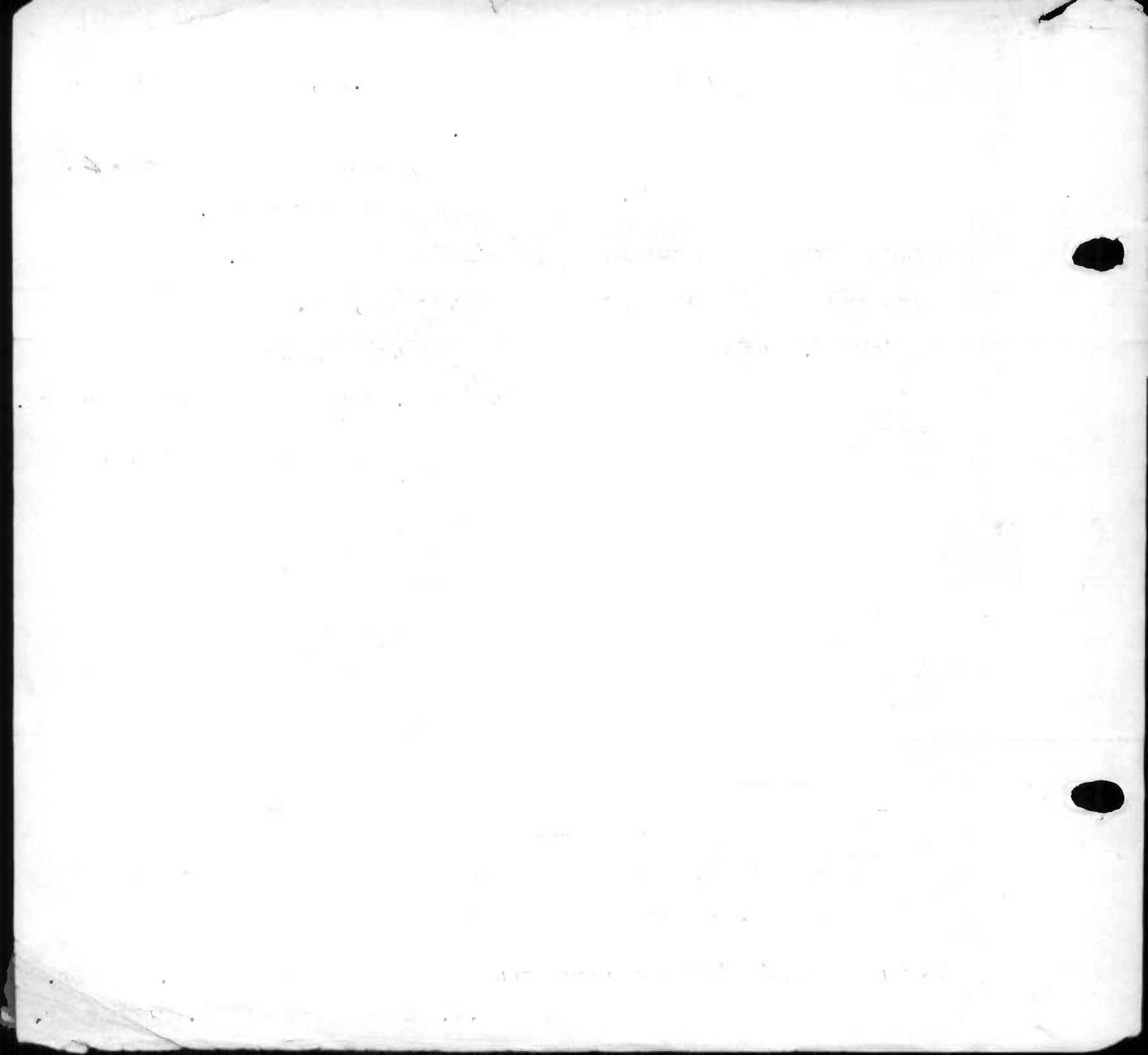


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11001</b>	
BIRTH NO. <b>67 11001</b>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>LENA BOSLEY</b>		2. DATE AND HOUR OF DEATH <b>Nov. 14, 1967</b>   <b>7:00 A.</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 3943 GREENMOUNT AVE.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>3943 GREENMOUNT AVE.</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>3/15/82</b>	9. AGE (in years last birthday) <b>85 YRS.</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOUSE WIFE</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>JOHN J. KLING</b>			
14. MOTHER'S MAIDEN NAME <b>CAROLINE BRACK</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <b>ALBERT C. BOSLEY 3943 GREENMOUNT AVE.</b>			
18. <b>433.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardio-vascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>November 7, 1967</b> to <b>November 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>November 7, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Lloyd E. Saylor</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Nov. 15, 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>Lloyd E. Saylor</b>		23D. ADDRESS M.D. <b>3902 Greenmount Avenue</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/18/67</b>		24C. NAME of CEMETERY or CREMATORY <b>PROSPECT HILL</b>	
24D. LOCATION (City, town, or county) (State) <b>TOWSON BALTO. MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 17 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Saylor</b>		25C. FUNERAL DIRECTOR <b>H.W. MEARS &amp; SON 805 N. CALVERT ST.</b>			





FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 67 11002				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 11002	
1. NAME OF DECEASED (Type or Print) <b>E. ELLA HORKY</b>				2. DATE AND HOUR OF DEATH <b>Nov. 13, 1967</b>		<b>40.</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>803 N. Port St.,</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.,</b> B. COUNTY <b>21205</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>803 N. Port St.</b>		<b>7-02</b>			
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>single</b>	8. DATE OF BIRTH <b>9/27/19</b>	9. AGE (In years last birthday) <b>48</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory Worker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Cross &amp; Blackwell</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Joseph Horky</b>				14. MOTHER'S MAIDEN NAME <b>Agnes Dobihal</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>320 Townsend Rd. Mrs. Marie Spangler, cousin,</b>			ADDRESS <b>21221</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>260 X I</b> CAUSE OF DEATH (A) <b>CORONARY OCCLUSION</b> DUE TO (B) <b>Diabetes Mellitus</b> DUE TO (C) <b>2-3 years</b>				INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>					
19. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Jan. 1966</b> to <b>9-19-67</b> 19 <b>67</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>9-19-67</b> 19 <b>67</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <b>Dr. Benjamin Moses</b>				23B. DATE SIGNED <b>11-15-67</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Benjamin Moses</b>			
23D. ADDRESS <b>448 N. Luzerne Ave.</b>		23E. FUNERAL DIRECTOR <b>Schimmek Funeral Home, Inc.</b>							
23F. ADDRESS <b>2601 E. Madison St.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>							
24B. DATE <b>11/17/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Bohemian Nat. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 17 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Schimmek Funeral Home, Inc.</b>					
25D. ADDRESS <b>2601 E. Madison St.</b>									

Current Account

Dr. John Smith

No

11-12-11

11-12-11

11-12-11

Dr. John Smith

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">67 11003</span>	
67 11003				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				HERMAN TRAUTNER	
2. DATE AND HOUR OF DEATH		11-15-67 3:29 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
35 Chord Home & Hospital		(336 S. Drew St.) Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		336 S. Drew St. 21224			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
M	W		4-20-1891	76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Police				Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
		218-28-05		Roderich Mueller	
				ADDRESS 7312 Bridgwood Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ACUTE MYOCARDIAL INFARCTION		A SCD		few hours	
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
cholelithiasis					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11-11-67 1967 to 11-15 1967, that (I) (we) last saw the deceased alive on 11-15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Roderich M. Mueller M.D.				11-15-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Roderich M. Linn M.D.				CHH	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		11-18-1967		Oak Lawn	
24D. LOCATION (City, town, or county)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
Md.		Thelma A. Hoffmann		3218 N. Linden St.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 17 1967		Robert E. Johnson		Thelma A. Hoffmann	

in about 1 hour & 10 minutes

at 10

10:10  
10:15

10:15-10:20

10:20

10:20-10:25

10:25

10:25-10:30

10:30

10:30-10:35

10:35-10:40

10:40

10:40-10:45

10:45-10:50

10:50

10:50-10:55

10:55-11:00

11:00

11:00

11:00-11:05

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11004				BALTIMORE CITY HEALTH DEPT. CERTIFICATE OF DEATH				Registered No. 67 11004					
1. NAME OF DECEASED (Type or Print) <i>John J. Welsh</i>				2. DATE AND HOUR OF DEATH <i>11-14-67 2:00 P.M.</i>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION <i>001316 Appleby Ave</i>				A. STATE <i>Md</i>				B. COUNTY					
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				21-15					
				D. STREET ADDRESS (If rural, give location) <i>1316 Appleby Ave</i>									
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED <i>Married</i>	8. DATE OF BIRTH <i>Sept 25 1897</i>		9. AGE (In years last birthday) <i>70</i>		10. If Under 1 Yr. Months		11. If Under 24 Hrs. Days		12. If Under 24 Hrs. Hours		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plasterer</i>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>Md</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John T. Welsh</i>				14. MOTHER'S MAIDEN NAME <i>Mary Smith</i>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>21801 0111</i>				17. INFORMANT <i>Estelle Welsh</i>				ADDRESS <i>1316 Appleby Ave</i>	
18. <i>420.11</i>				CAUSE OF DEATH <i>Coronary occlusion</i>				INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO									
(C) DUE TO													
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.													
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>Nov 13 1967</i> to <i>Nov 14 1967</i> , that (I) ( <del>was</del> ) lost saw the deceased alive on <i>Nov 13 1967</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>has</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.													
23A. SIGNATURE <i>William G. Helfrich</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>11-15-67</i>					
23C. PHYSICIAN'S NAME (Type) <i>William G. Helfrich</i>				23D. ADDRESS <i>5006 Roland Ave Baltimore 21210</i>									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>11-17-67</i>				24C. NAME OF CEMETERY or CREMATORY <i>Druid Ridge Cem.</i>				24D. LOCATION (City, town, or county) (State) <i>Pikesville Balto Co Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 17 1967</i>				25B. NAME OF REGISTRAR <i>Robert E. Tankersley</i>				25C. FUNERAL DIRECTOR <i>Burger Funeral Home</i>				ADDRESS <i>3631 Fall Rd Byrdview, Baltimore</i>	



# FUNERAL DIRECTOR: IMPORTANT

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67 11005

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

67 11005

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

William N. Knickman

2. DATE AND HOUR OF DEATH

November 14, 1967

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(If not in hospital or institution, give street  
address or location)

00  
2900 Mallview Rd. 21230

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2900 Mallview Rd.

25-42

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

1/27/11

9. AGE (In years  
last birthday)

56

If Under 1 Yr.  
Months: Days:

If Under 24 Hrs.  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Foreman

10B. KIND OF BUSINESS OR INDUSTRY

Md. Glass Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Knickman

14. MOTHER'S MAIDEN NAME

Anna Stonesifer

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

216-10-8038

17. INFORMANT

Ett A. Knickman 2900 Mallview Rd.

ADDRESS

18. 527.1 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, osthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

Pulmonary emphysema

(A) Cor Pulmonale

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH  
2 years  
1 year

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 19 65 to Nov 14, 1967  
that (I) (we) last saw the deceased alive on Nov 12, 67 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Paul Schonfeld

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

11/16/67

23C. PHYSICIAN'S  
NAME (Type)

Paul Schonfeld

23D. ADDRESS

M.D. 2301 Annapolis Rd.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

11/18/67

24C. NAME of CEMETERY or CREMATORY

Louisa Park Cemetery

24D. LOCATION

Baltimore, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 17 1967

25B. NAME OF REGISTRAR

Robert E. Farkner

25C. FUNERAL DIRECTOR

Ambrose Inc 1328 Sulphur Sp. Rd

ADDRESS

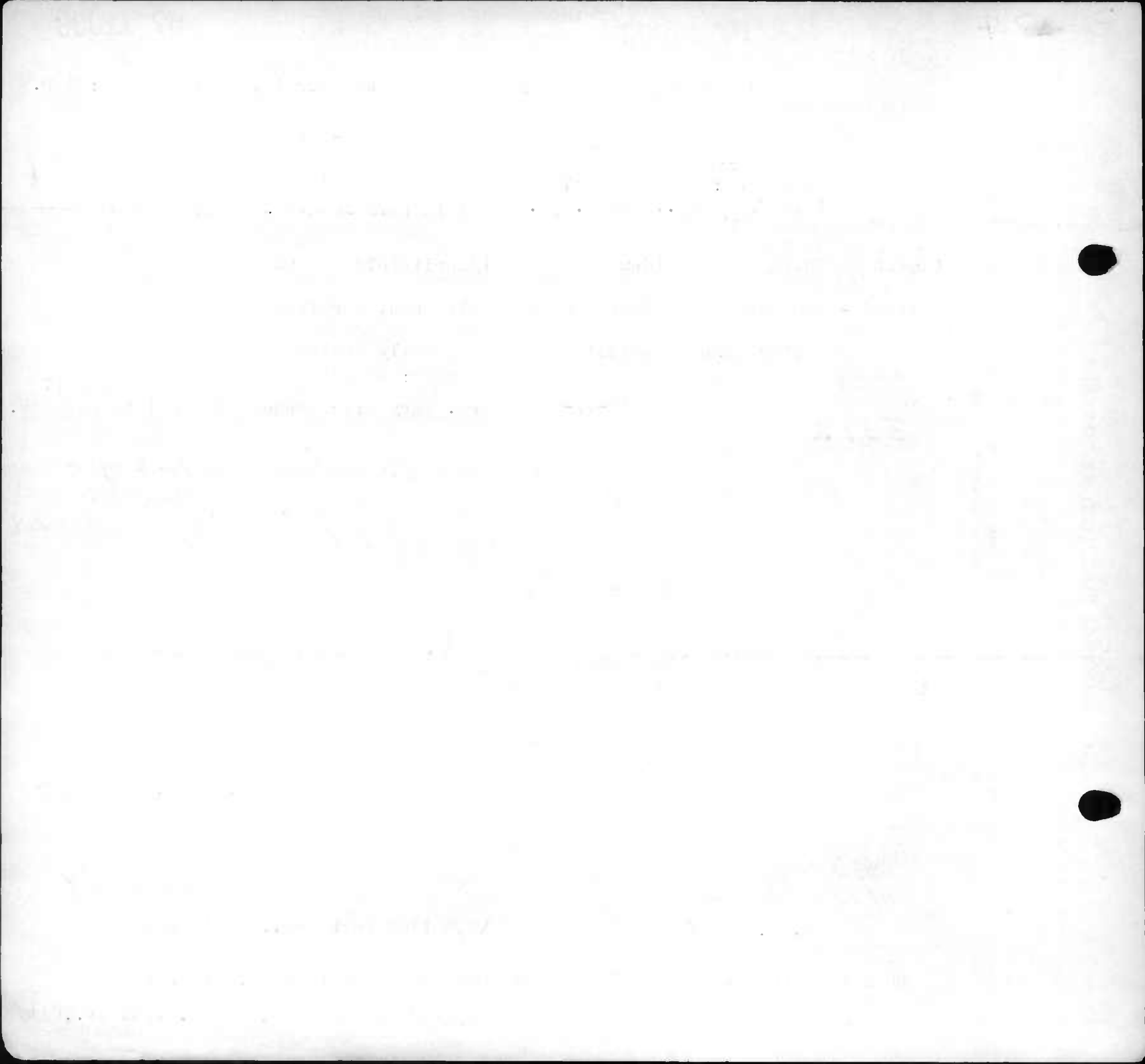
Old paper and



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>67 11006</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>67 11006</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>PRIMROSE CASSELL BERKELEY</b>		2. DATE AND HOUR OF DEATH <b>November 15, 1967 4:30 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> - No County		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>City of Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>RESIDENCE: 21217 1512 Park Ave., Balto. Md.</b>		D. STREET ADDRESS (If rural, give location) <b>1512 Park Avenue - 21217</b>		14-01	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>1/April/1874</b>	9. AGE (In years last birthday) <b>93</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Manager</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Apartment House</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Charles Emmett Cassell</b>		14. MOTHER'S MAIDEN NAME <b>Sally Bowles</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-10-6389A</b>		17. INFORMANT: <b>Daughter</b> ADDRESS <b>City 17 1512 Park Av.</b>	
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Cerebro Vascular Disease 1-3 yrs Advanced</b> (B) <b>Congestive Heart Disease 2-5 days</b> (C) <b>Generalized Arterio-sclerosis Gradual</b>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Oct 1950</b> 19 to <b>Nov 15</b> 1967, that (I) (we) last saw the deceased alive on <b>Nov 14</b> 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. H. WOODE</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11-16-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>W. H. WOODE</b>		23D. ADDRESS M.D. <b>1403 Park Ave., Baltimore</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>18/Nov/1967</b>		24C. NAME of CEMETERY or CREMATORY <b>Cedar Grove Cemetery</b>	
24D. LOCATION <b>Portsmouth, Virginia</b>		24E. DATE REC'D BY HEALTH DEPT. <b>NOV 17 1967</b>			
25A. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25B. FUNERAL DIRECTOR <b>STEWART &amp; MOWEN CO.</b>		25C. ADDRESS <b>108 W. North Av., City</b>	



FUNERAL DIRECTOR: IMPORTANT

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1K-6010

67 11007

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

67 11007

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JAMES C. KERR SR

2. DATE AND HOUR OF DEATH

Nov. 14, 1967 2:25 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

49 NORTH CHARLES GEN. HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

MARYLAND

Balt. Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

53-00

D. STREET ADDRESS (If rural, give location)

101 Riverside Rd

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

6-7-96

9. AGE (In years last birthday)

71

10. Under 1 Yr. Months: Days:

11. Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

BETH. STEEL

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

GEORGE KERR

14. MOTHER'S MAIDEN NAME

MARY BURK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

UNK

16. SOCIAL SECURITY NO.

213-07-4524

17. INFORMANT

GRACE KERR

ADDRESS

101 RIVERSIDE RD

18.

153.8 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Subdiaphragmatic abscess

(B) DUE TO

Peritoneal abscess

2 wks ago

(C) DUE TO

Ca Colon & AP repair

2 yrs ago

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-6-1967 to 11-14-1967, that (I) (we) last saw the deceased alive on 11-14-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Manuel J. Tan

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

Nov. 14, 1967

23C. PHYSICIAN'S NAME (Type)

MANUEL J. TAN

23D. ADDRESS

M.D.

North Charles Gen. Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

11/17/67

24C. NAME OF CEMETERY or CREMATORY

BEL AIR MEM.

24D. LOCATION

(City, town, or county)

HARTFORD CO.

(State)

MD

25A. DATE REC'D BY HEALTH DEPT.

NOV 17 1967

25B. NAME OF REGISTRAR

Robert E. Fairbank

25C. FUNERAL DIRECTOR

Connolly/H.

ADDRESS

300 Moore

NORTH AVENUE GEN HOSPITAL  
 BALTIMORE  
 MARYLAND  
 101 BALTIMORE ST  
 2-7-62  
 11

GEORGE KEENE  
 MARY JANE  
 PENNSYLVANIA  
 02-0

Journal of TAN  
 MANUEL J TAN  
 11-14-  
 11-6-62  
 11-14-62  
 X  
 State Clerk Gen Hospital  
 Nov 14 1962

67 11008

BALTIMORE CITY HEALTH DEPARTMENT

67 11008

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE DIMICK SR.

2. DATE AND HOUR PRONOUNCED DEAD

November 15, 1967 11:50 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

31 City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

111 Riverside Ave. DR.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

NOV. 27, 1894

9. AGE (In years  
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

MARTINS

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN DIMICK

14. MOTHER'S MAIDEN NAME

ANNIE BARTHOLOMEW

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

UNK

16. SOCIAL  
SECURITY NO.

215-01-8496

17. INFORMANT

JAMES DIMICK

ADDRESS

CHESTER RD

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Pneumonia  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Subdural hemorrhage

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Eastern Blvd. &amp; Taylor Ave.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
10 15 67 2:10

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subject tripped and fell striking his  
head

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

11/18/67

23C. NAME OF CEMETERY or CREMATORY

GARDENS OF FAITH

23D. LOCATION

BALTO. MD.

24A. DATE REC'D BY HEALTH DEPT.

NOV 17 1967

24B. NAME OF REGISTRAR

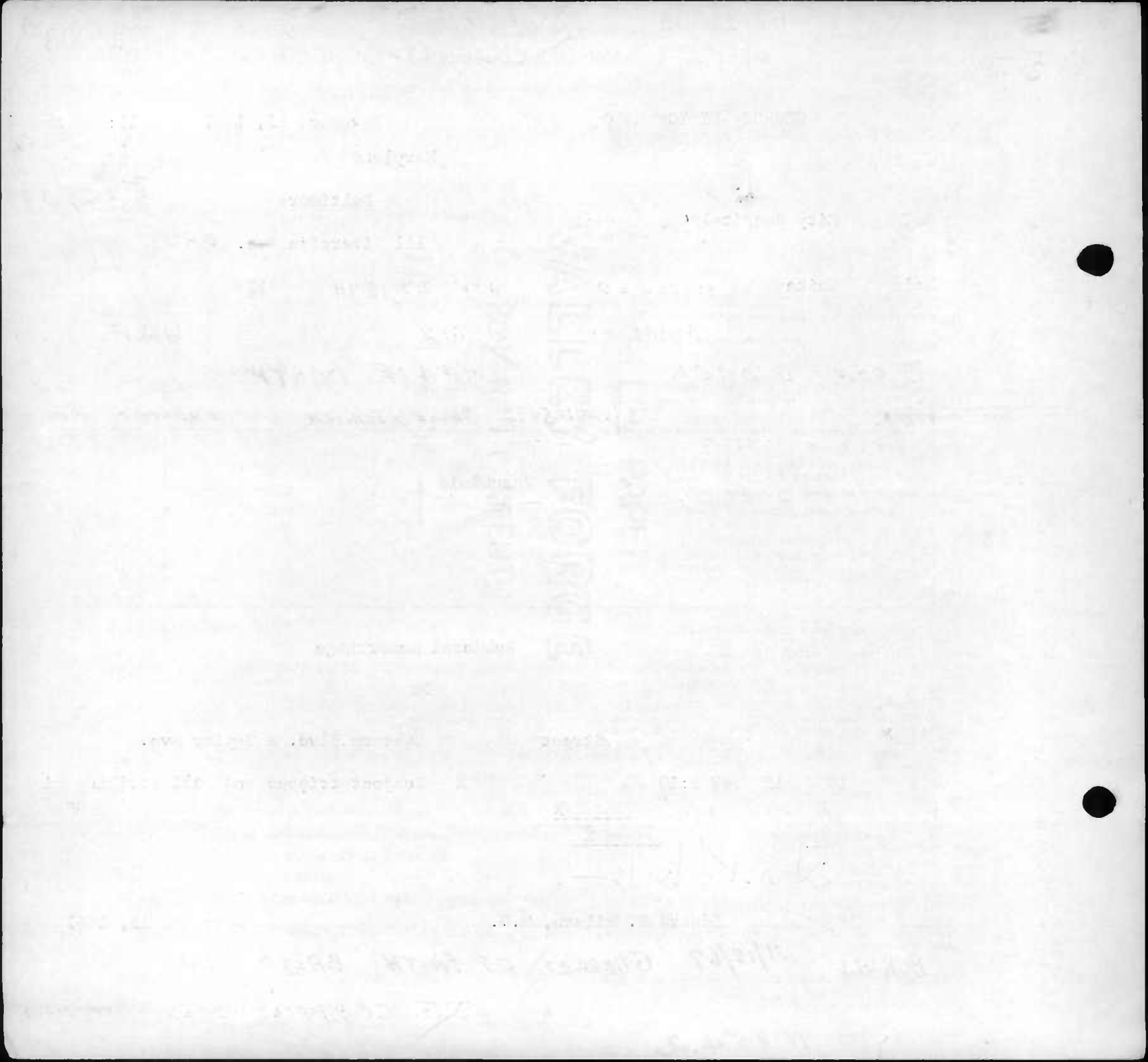
Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

J.G. CONNELLY SONS

ADDRESS

300 MACE



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 11009		<b>CERTIFICATE OF DEATH</b>		67 11009	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print)		
			Barbara Hofmeister		
2. DATE AND HOUR OF DEATH			2:45 AM 11-14-67		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Md. General Hospital			Md. Baltimore		
48 Baltimore Md			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore 26-01		
D. STREET ADDRESS (If rural, give location)			6605 Belair Rd		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
F	W	W	5-1-76	41	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Housewife		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Joseph Klecka			Mary Hranicka		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		217-01-3405T		Chart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
331X I			(A) Cerebral hemorrhage		
DUE TO			3 days		
ANTECEDENT CAUSES			(B) Arteriosclerosis		
DUE TO			5 —		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-9 1967 to 11-14 1967, that (I) (we) last saw the deceased alive on 11-14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
L. KEMPER OWENS M.D.				11-14-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
L. KEMPER OWENS		1410 Balto St Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	11-17-67	Bohemian National Cemetery		Baltimore City Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 17 1967		Robert E. Farber		Lassahn Fritz Kopp 7401 Belair Rd.	

Dearest, I have just  
received your letter

Yours truly  
J. H. Brown

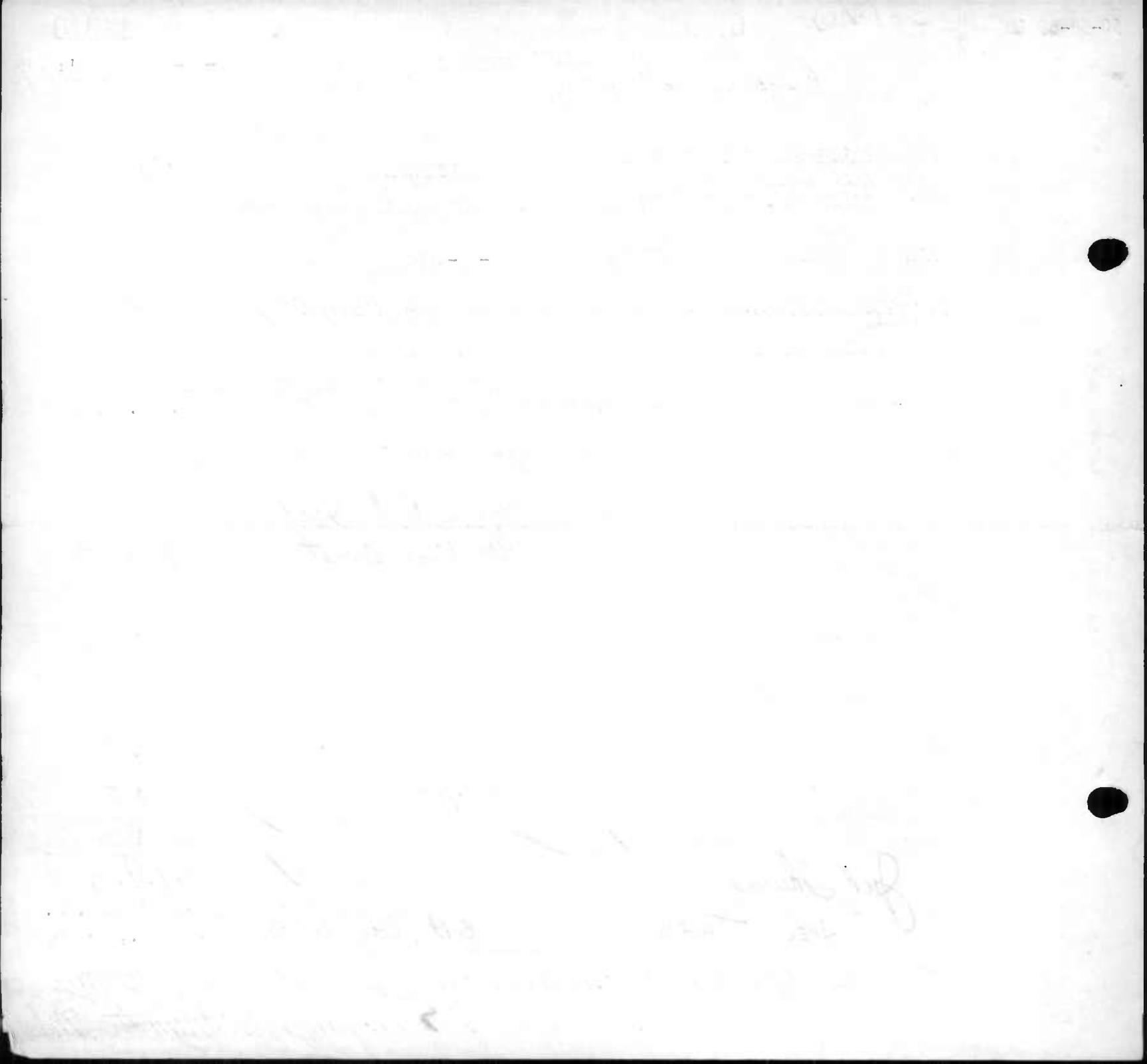


50-58-59 LB 1

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>5-140</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 11010</b>	
M.E. CASE NO.		EUGENE SHIPLEY		2. DATE AND HOUR OF DEATH <b>11-14-67 8:30PM</b>	
1. NAME OF DECEASED (Type at Print) <b>Eugene Shipley</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>420 WAMPLER ROAD 21220</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>4-20-1885</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OWNER AND OPERATOR OF LUNCH ROOM</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND (Carmel Co.)</b>	
13. FATHER'S NAME <b>EDWARD CRAFT</b>		14. MOTHER'S MAIDEN NAME <b>AMANDA GREEN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-36-4163 A</b>		17. INFORMANT ADDRESS <b>RECORDS: BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MD. 21224</b>	
18. <b>4201 I</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Arteriosclerotic Heart Disease</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Myocardial Ischemia</b>			
		(C) <b>Cardiac Arrest</b> <b>15 minutes</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/14/67</b> 19 to <b>11/14/67</b> 19, that (I) (we) last saw the deceased alive on <b>11/14/67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Joel Thurm</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/14/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOEL THURM</b>		23D. ADDRESS <b>BALTIMORE CITY HOSPITALS BALTO. MD. 4940 EASTERN AVE., 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/17/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>CARROLLTON CHURCH OF GOD FINKSBURG, RD MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 17 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR <b>J. S. Myers, Jr., Westminster, Md.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11011</b>	
BIRTH NO. <b>67 11011</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <b>11-14-67 11:50 P M.</b>			
1. NAME OF DECEASED (Type or Print) <b>Broening William F Jr.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>4720 Liberty Hgts Ave</b>			
3. PLACE OF DEATH <b>BALTIMORE, MARYLAND</b>		5. SEX <b>M</b> 6. RACE <b>White</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>SINGLE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI Hosp</b>		8. DATE OF BIRTH <b>6-22-06</b> 9. AGE (in years last birthday) <b>61</b> 10. If Under 1 Yr. Months: Days: 11. If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate Insurance</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>retired</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William F Broening Sr.</b>		14. MOTHER'S MAIDEN NAME <b>J. Marie Gravel</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>21632-7570</b>		17. INFORMANT <b>Mrs Fulemider Rt 2. Lyons Mill Rd oking mill.</b> ADDRESS	
18. <b>260X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Anterior External hemorrhage 2nd to 7th floor.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Diabetes mellitus</b> <b>Diabetes mellitus</b>		CAUSE OF DEATH (A) <b>Anterior External hemorrhage 2nd to 7th floor.</b> (B) <b>Diabetes mellitus</b> (C) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24+ hrs</b> <b>35 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2 NA</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NA</b>		20A. AUTOPSY (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NA</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NA</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NA</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>NA</b>		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(1)</del> (this hospital) attended the deceased from <b>11-13-67</b> to <b>11-14</b> 19 <b>67</b> , that (I) <del>(was)</del> last saw the deceased alive on <b>11-14-67</b> and that in (my) <del>(was)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(was)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>Ed Barry Alperstein</b>				23B. DATE SIGNED <b>11-14-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ed Barry Alperstein</b>				23D. ADDRESS <b>Sinai Hospital Baltimore Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11-17-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>NOV 17 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, MA</b>	
25C. FUNERAL DIRECTOR <b>Ellsworth Armacost</b>		ADDRESS <b>4600 Liberty Hgts Ave</b>			

10-2-2-3

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10-2-2-3

10-2-2-3

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11012

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>Rollin</b> <b>X <del>Rollin</del> E. PARRACK</b>			2. DATE AND HOUR PRONOUNCED DEAD <b>November 14, 1967</b> <b>6:45</b> p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>31 City Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>540 S. 48th Street</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. <del>MARRIED</del> , NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>9-29-1917</b>	9. AGE (In years last birthday) <b>50</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Motor Inspector</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co</b>		11. BIRTHPLACE (State or foreign country) <b>Preston Co. W. Virginia</b>	
13. FATHER'S NAME <b>Ernest Parrack</b>			14. MOTHER'S MAIDEN NAME <b>Sylvia Sloughaugh</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-12-9197</b>		17. INFORMANT ADDRESS <b>Helaine Parrack 540 S. 48th Street</b>	
18. <b>443X</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> (A) DUE TO  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>November 15, 1967</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>II-18-67</b>		23C. NAME of CEMETERY or CREMATORY <b>Moreland Memorial Park</b>	
23D. LOCATION <b>Baltimore, Maryland</b>		24A. DATE REC'D BY HEALTH DEPT. <b>NOV 17 1967</b>			
24B. NAME OF REGISTRAR <b>Robert E. Isakson</b>		24C. FUNERAL DIRECTOR ADDRESS <b>Walter Dabrowski 1005 Dundalk Avenue</b>			

WALTON FORDS

WALTON FORDS

WALTON FORDS

BIRTH NO. *Cecil Jmd* MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. *X*

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

VONNIE

K.

RITCHIE

2. DATE AND HOUR PRONOUNCED DEAD

November 14, 1967

1:38 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Rte #1, Rising Sun, Maryland

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

NOV. 27, 1965

9. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

23

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

CLINE O. RITCHIE

14. MOTHER'S MAIDEN NAME

RITA I. COULSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MRS RITA I. RITCHIE, RISING SUN, MD.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Bronchopneumonia Complicating Injuries  
DUE TOANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Intersection of State Rte 274 &  
Post Road21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

11/3/67

7:20 P.m.

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Passenger in auto-auto collision

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

11/15/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

11/16/67

23C. NAME OF CEMETERY or CREMATORY

HOPEWELL

23D. LOCATION

(City, town, or county)

(State)

PORT DEPOSIT, MD.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

NOV 17 1967

Ralph E. Farley

RALPH M. REED

RISING SUN, MD.

NOV 27 1952

AMERICAN

AMERICAN

COLEMAN, C. FITCHIE R. TO THE

AND ALSO A MEMORANDUM

FROM THE

AMERICAN

NOV 27 1952



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 11014	
BIRTH NO. 67 11014		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PETER J. LIPINSKI		2. DATE AND HOUR OF DEATH November 14, 1967 3:35 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 00 2120 E. Fayette Street		D. STREET ADDRESS (If rural, give location) 2120 E. Fayette Street		6-03	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 6/30/91	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer- (Retired)		10B. KIND OF BUSINESS OR INDUSTRY Metal Cap Mfg.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Peter Lipinski		14. MOTHER'S MAIDEN NAME Josephine Fabiszak	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-01-6749		17. INFORMANT Mr. Melvin Lipinski, 5126 McPhaul Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I Crownary Thrombosis		CAUSE OF DEATH (A) DUE TO Crownary Thrombosis (B) DUE TO Arteriosclerosis Cardiovascular Disease (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 11/14/67 5 yr	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-10 1967 to 10/14 1967 that (I) (we) last saw the deceased alive on 11/14 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph G. Laukaitis MD		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/15/67	
23C. PHYSICIAN'S NAME (Type) Joseph G. LAUKAITIS MD		23D. ADDRESS 679 Washington Blvd Baltimore 30 Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/18/67		24C. NAME OF CEMETERY or CREMATORY Holy Rosary	
24D. LOCATION Baltimore, Maryland		24E. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE		24F. ADDRESS 1808 EASTERN AVE	
25A. DATE REC'D BY HEALTH DEPT. NOV 17 1967		25B. NAME OF REGISTRAR Robert E. Farley			

George Washington  
Washington, D.C.

1791  
George Washington  
Washington, D.C.

67 11015

BALTIMORE CITY HEALTH DEPARTMENT

67 11015

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

STEPHEN GEORGE PINOS

2. DATE AND HOUR PRONOUNCED DEAD

November 13, 1967 7:35 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

South Baltimore General Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland A. A.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

623 Wood Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Jan. 7, 1913

9. AGE (In years  
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Electrical Inspector

10B. KIND OF BUSINESS OR INDUSTRY

Fire Underwriters Portage, Pa.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.

13. FATHER'S NAME

Joseph Pinos

14. MOTHER'S MAIDEN NAME

Anna Haur lasin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

212-01-4847

17. INFORMANT

ADDRESS

Agnes R. Pinos - 623 Wood St., Baltimore

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic heart disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?  
Yes21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 13, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11-16-1967

23C. NAME of CEMETERY or CREMATORY

Holy Cross Cemetery

23D. LOCATION (City, town, or county) (State)

Ritchie Hgwy., A.A.Co., Maryland

24A. DATE REC'D BY HEALTH DEPT.

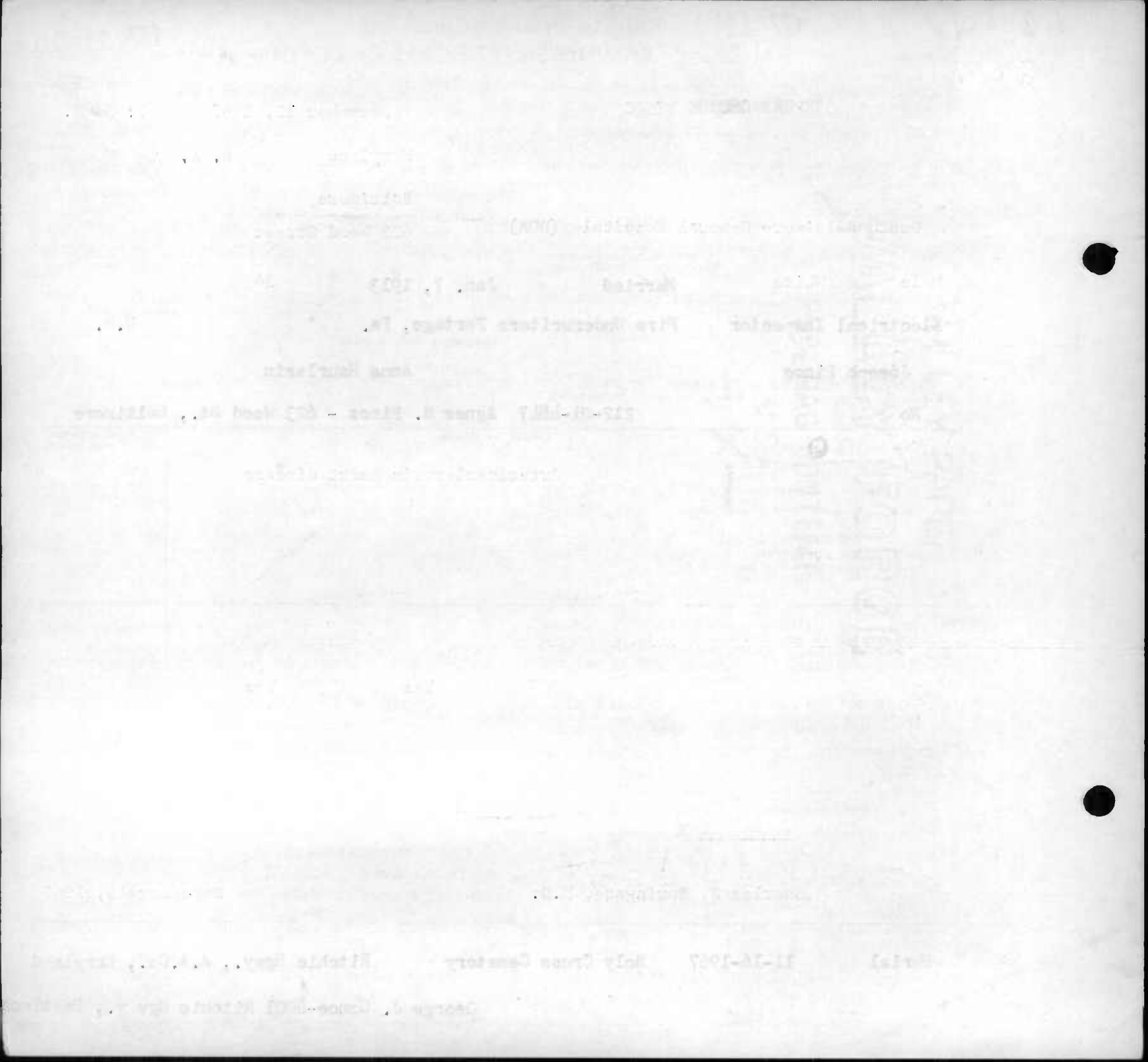
NOV 17 1967

24B. NAME OF REGISTRAR

Robert E. Farky

24C. FUNERAL DIRECTOR

George J. Gonce-4001 Ritchie Hgwy., Baltimore



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11016</b>	
67 11016				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Wrzesinski, Stanley</b>				<b>11-15-67 6 20 A. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>North Charles General Hospital</b>		A. STATE <b>Maryland</b>		B. COUNTY	
(If not in hospital or institution, give street address or location) <b>49 2724 N. Chas. St. 21218</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		<b>25-04 21225</b>	
D. STREET ADDRESS (If rural, give location) <b>3947 Brooklyn Ave.</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>10-30-81</b>	9. AGE (In years last birthday) <b>86</b>	10. Under 1 Yr. Months Days : 11 Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Mt. Car Wheel Foundry</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>	
13. FATHER'S NAME <b>Wrzesinski, (Unknown)</b>		14. MOTHER'S MAIDEN NAME <b>(Unknown)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NI</b>		16. SOCIAL SECURITY NO. <b>212-16-0718</b>		17. INFORMANT <b>chart</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>162.1 I</b>		CAUSE OF DEATH <b>Broncopneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>recent</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <b>Asymptomatic cancer</b>		<b>many years</b>	
		(B) DUE TO <b>Bronchogenic ca, 2 lungs</b>			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. I certify that (I) (this hospital) attended the deceased from <b>9-19 1967</b> to <b>11-15 1967</b> , that (I) (we) last saw the deceased alive on <b>11-15 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-15-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Flax, Leonard</b>		23D. ADDRESS <b>2702 North Charles Street #21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-18-1967</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Cross Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Ritchie Hgwy., A.A.Co., Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 17 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Tarkenton</b>	
25C. FUNERAL DIRECTOR <b>George J. Gonce</b>		ADDRESS <b>4001 Ritchie Hgwy., Baltimore</b>			

1000 ft. above sea level

Brachycephalus  
Brachycephalus

1/2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
67 11017 CERTIFICATE OF DEATH

Registered No.

67 11017

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Agnes A Rausch

2. DATE AND HOUR OF DEATH

Nov 13 1967 3:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(If not in hospital or institution, give street  
address or location)

90 Harford Garden Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD

BALTO C

C. CITY OR TOWNSHIP (If outside city limits, write RURAL and give township)

BARKVILLE

53-00

D. STREET ADDRESS (If rural, give location)

3031 Linwood Ave

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

Jan 7 1893

9. AGE (In years  
lost birthday)

74

10. Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

At. Home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Anthony Primus

14. MOTHER'S MAIDEN NAME

Maria Lehky

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

Family records

ADDRESS

18.

151X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) DUE TO

Carcinoma of stomach

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

8 months

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐

Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Sept. 6 1967 to Nov. 13 1967,  
that (I) (we) last saw the deceased alive on November 12 1967 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Loy M. Zimmerman

M.D.

Attending  
Phys. ☒

Med.  
Director ☐

Staff  
Phys. ☐

23B. DATE SIGNED

11/14/67

23C. PHYSICIAN'S  
NAME (Type)

Loy M. Zimmerman

M.D.

23D. ADDRESS

3202 Harford Rd. Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11-16-67

24C. NAME OF CEMETERY OR CREMATORY

Parkwood cemetery

24D. LOCATION

(City, town, or county)

Baltimore Co.

Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 17 1967

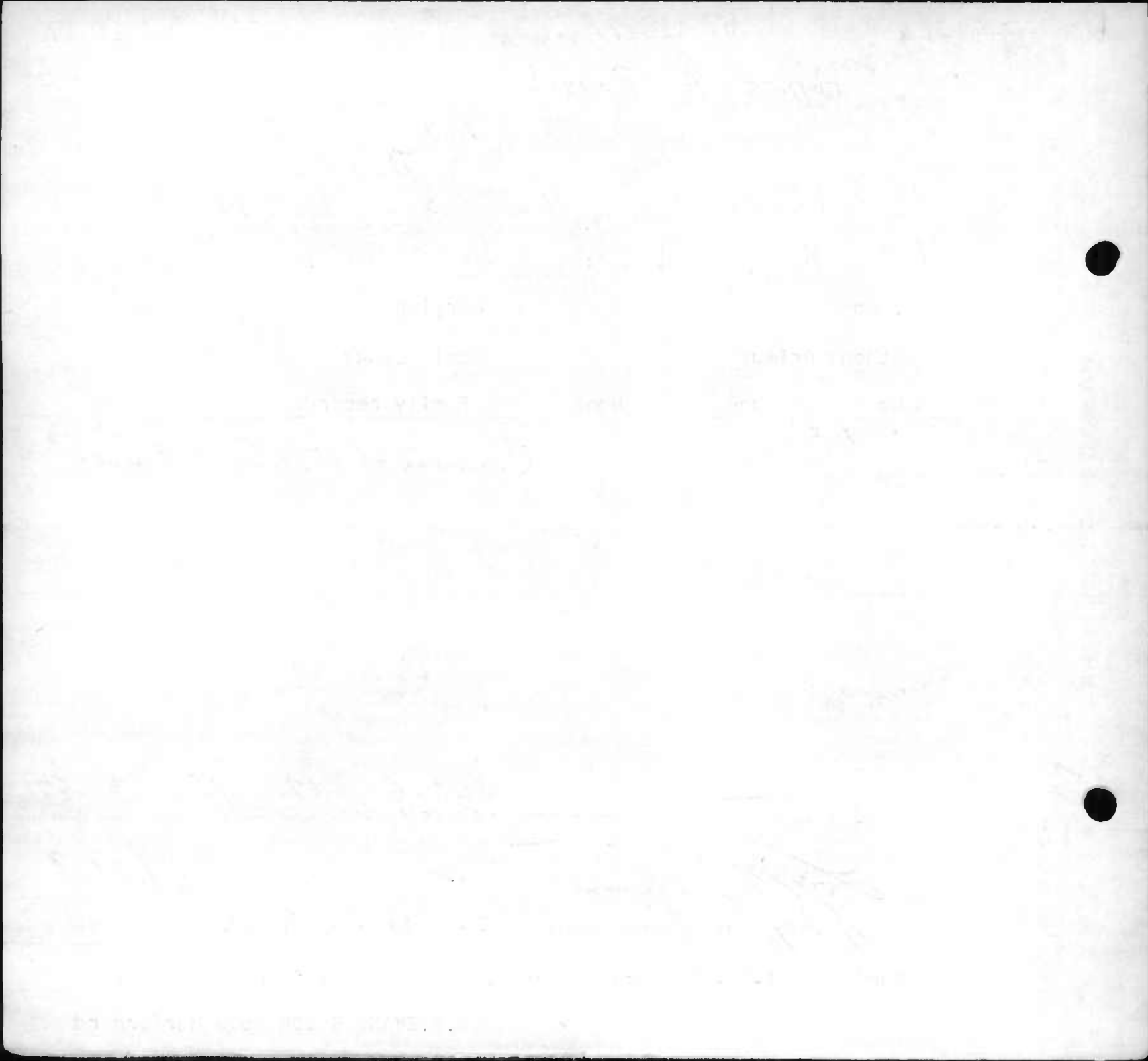
25B. NAME OF REGISTRAR

Robert E. Jarkey

25C. FUNERAL DIRECTOR

C.F. EVANS & SON 8802 Harford rd

ADDRESS

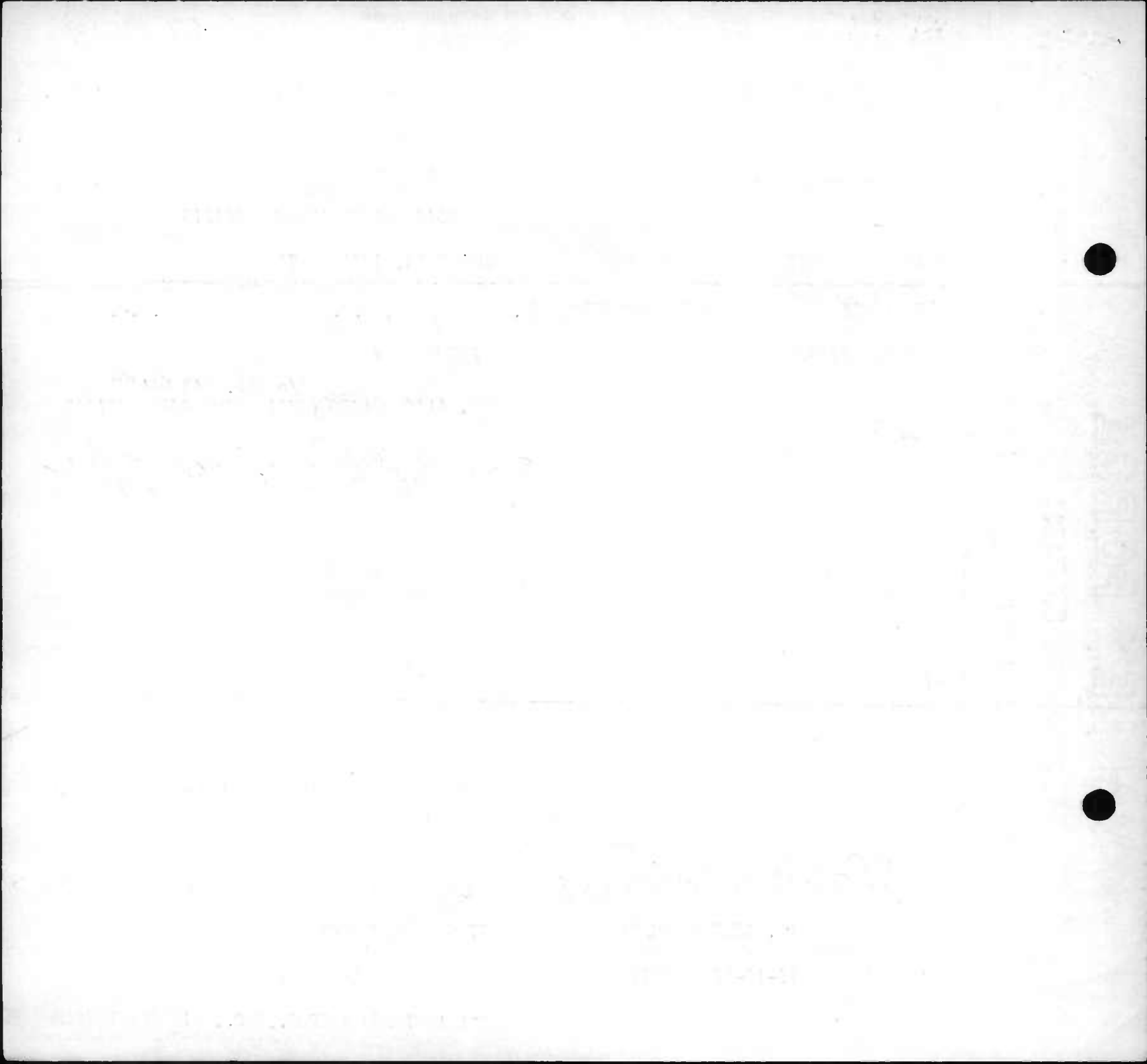




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 11018					67 11018				
BIRTH NO. <u>W-360</u>					REGISTERED NO. <u>67 11018</u>				
M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <u>JACOB WIDROW</u>					NOVEMBER 14, 1967 9:35 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL</u>					A. STATE <u>MARYLAND</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>				
					D. STREET ADDRESS (If rural, give location) <u>5313 NELSON AVENUE #21215</u>				
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>AUGUST 14, 1892</u>	9. AGE (In years last birthday) <u>75</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EMPLOYEE</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>REECE FURNITURE CO.</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>HYMAN WIDROW</u>					14. MOTHER'S MAIDEN NAME <u>ESTHER ?</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>c/o MRS. MAX GALANT</u> <u>MRS. ALICE WIDROW, 4751 BYRON ROAD #21208</u>				
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) <u>Beate Myocardial Infarction</u> (B) <u>Anticoagulant C.P.</u> (C) <u>292</u>			INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>Feb 5, 1959</u> to <u>Nov 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 14, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Lester Kolman</u>					23B. DATE SIGNED <u>Nov 14, 1967</u>				
23C. PHYSICIAN'S NAME (Type) <u>DR. LESTER KOLMAN</u>					23D. ADDRESS <u>3700 PARK HEIGHTS AVENUE</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11-16-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>CHIZUK AMINO</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 17 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, MD</u>			25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., INC.</u>		ADDRESS <u>6010 REISTERSTOWN RD</u>		



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>15-165</span> <span>67 11019</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="display: flex; justify-content: space-between;"> <span></span> <span><b>CERTIFICATE OF DEATH</b></span> <span>Registered No. <b>67 11019</b></span> </div>			
BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <b>SAFFRON, IRENE</b>		2. DATE AND HOUR OF DEATH <b>9:50 am 11-18-67</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> <b>53-00</b>	
		D. STREET ADDRESS (If rural, give location) <b>7932 DUNDHILL Village Circle #7</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b> (specify)	8. DATE OF BIRTH <b>4/22/1913</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES LADY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>	9. AGE (In years last birthday) <b>54</b>
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ISAAC MILLER</b>		14. MOTHER'S MAIDEN NAME <b>IDA BECKER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MR. DAVID H. COHEN, 110 E. LEXINGTON ST.</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebrovascular Thrombosis</b>		CAUSE OF DEATH (A) DUE TO <b>Renal cell carcinoma</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>multisystem metastasis</b>		(B) DUE TO <b>multisystem metastasis</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>pulmonary embolism</b>		(C) DUE TO	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10/24/67</b> 19 <b>67</b> to <b>Nov 14</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Nov 14</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Alan F. Wolf</b>		23B. DATE SIGNED <b>11/14/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALAN F. WOLF</b>		23D. ADDRESS <b>C/O Sinai Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11-15-67</b>	
24C. NAME OF CEMETERY or CREMATORY <b>CHIZUK AMUNO</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>	
25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD</b>		ADDRESS	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11020

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)BESSYE S.  
~~BESSYE~~ GENDERSON

2. DATE AND HOUR PRONOUNCED DEAD

November 12, 1967 1:22 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)42  
99 Sinai Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

100 W. Coldspring Lane

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

WIDOW

8. DATE OF BIRTH

7-24-1908

9. AGE (In years  
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

SECRETARY

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HARRY L. SACKS

14. MOTHER'S MAIDEN NAME

REBECCA SOLLWITZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MRS. IRENE SANDLER, 3806 FALLSTAFF RD. 1st FLOOR

18.

E 819.4

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Multiple traumatic injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Kelly Ave. 39' west of Lochlea Road

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
11-12-67 1:00 P.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Driver of auto that  
struck curb and a pole.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

November 13, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

11-14-67

23C. NAME OF CEMETERY or CREMATORY

MOGAN ABRAHAM

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

NOV 17 1967

Robert E. Farber, M.D.

SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD

7-24-1962

RECEIVED

COMMUNICATIONS SECTION

UNITED STATES DEPARTMENT OF DEFENSE

RECEIVED  
7-24-1962  
COMMUNICATIONS SECTION

67 11021

BALTIMORE CITY HEALTH DEPARTMENT

67 11021

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HENRIETTA

~~SACKS~~ SACKS

2. DATE AND HOUR PRONOUNCED DEAD

November 12, 1967

1:22 P.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)42  
99  
Sinai Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

100 W. Coldspring Lane

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

4-12-1902

9. AGE (In years  
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

SECRETARY

10B. KIND OF BUSINESS OR INDUSTRY

MD. STATE PLANNING

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HARRY L. SACKS

14. MOTHER'S MAIDEN NAME

REBECCA SOLLOWITZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MRS. IRENE SANDLER, 3806 FALLSTAFF RD., 1st FLOOR

18. E 819.4 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Multiple traumatic injuries

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Kelley Ave. 39' west of Lochlea Road

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
11-12-67 1:00 P.

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE AT  
WORK

21F. HOW DID INJURY OCCUR?

Passenger in auto that struck curb and  
a pole.

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 13, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

11-14-67

23C. NAME OF CEMETERY or CREMATORY

MOGAN ABRAHAM

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

NOV 17 1967

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD

ADDRESS

WILLIAMS & SONS

4-13-1962

STATION

STATION

STATION

STATION

STATION

STATION

STATION

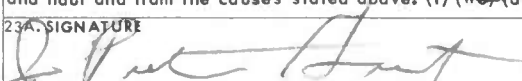
STATION

STATION



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 11022</b>	
BIRTH NO. <b>67 11022</b>		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>JOHN SCOTT McNEILL</b>		<b>11-15-67</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>00 1063 Ellicott Drive</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1063 Ellicott Drive</b>	
5. SEX <b>M.</b>	6. RACE <b>N.</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b>	8. DATE OF BIRTH <b>3-18-1894</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>73</b>
11. BIRTHPLACE (State or foreign country) <b>RAEFORD, NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN McNEILL</b>		14. MOTHER'S MAIDEN NAME <b>ANN McNEILL</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>239-22-6615</b>	17. INFORMANT ADDRESS <b>Mrs. Clara Hatchett 1063 Ellicott Dr.</b>
18. <b>420.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>ASIA 2 Cong. Failure 11 Months</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO	
(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/2/65</b> 19 to <b>11/15</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11/8</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED <b>11/16/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. Preston Grant,</b>		23D. ADDRESS <b>601 N. Carrollton Ave. Balto., Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>11-19-67</b>	24C. NAME of CEMETERY or CREMATORY <b>SILVER GROVE CEMETERY</b>	24D. LOCATION (City, town, or county) (State) <b>RAEFORD, NORTH CAROLINA</b>
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 17 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR ADDRESS <b>MORTON &amp; DYETT F.H. 1701 Laurens St.</b>

10

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11023		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11023	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		Mamie LEWIS (Jane)		2. DATE AND HOUR OF DEATH 11-13-67 1:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY BALTIMORE	
The Johns Hopkins Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
		D. STREET ADDRESS (If rural, give location)		424 New Pittsburg Ave.	
5. SEX FEMALE	6. RACE NEGROID	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 3-20-1931	9. AGE (In years last) 36	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
COOK		LUNCHROOM		APPOMATTAX XO., VA.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
CLAUDE NELSON LEWIS		ROSA BEASLEY		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Mrs. Margaret Hill 424 New Pittsburg	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) UREMIA		3 wks	
ANTECEDENT CAUSES		(B) DIABETES MELLITUS		4 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 10-24 19 67 to November 13 19 67		that (X) (we) last saw the deceased alive on 11-13-67 19		and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED			
John V. Russo		11-13-67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
John V. Russo		Johns Hopkins Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		11-18-67		MOUNT CALVARY CEM.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 17 1967		Robert E. Leiby		MORTON DYE 1701 LAURENS	

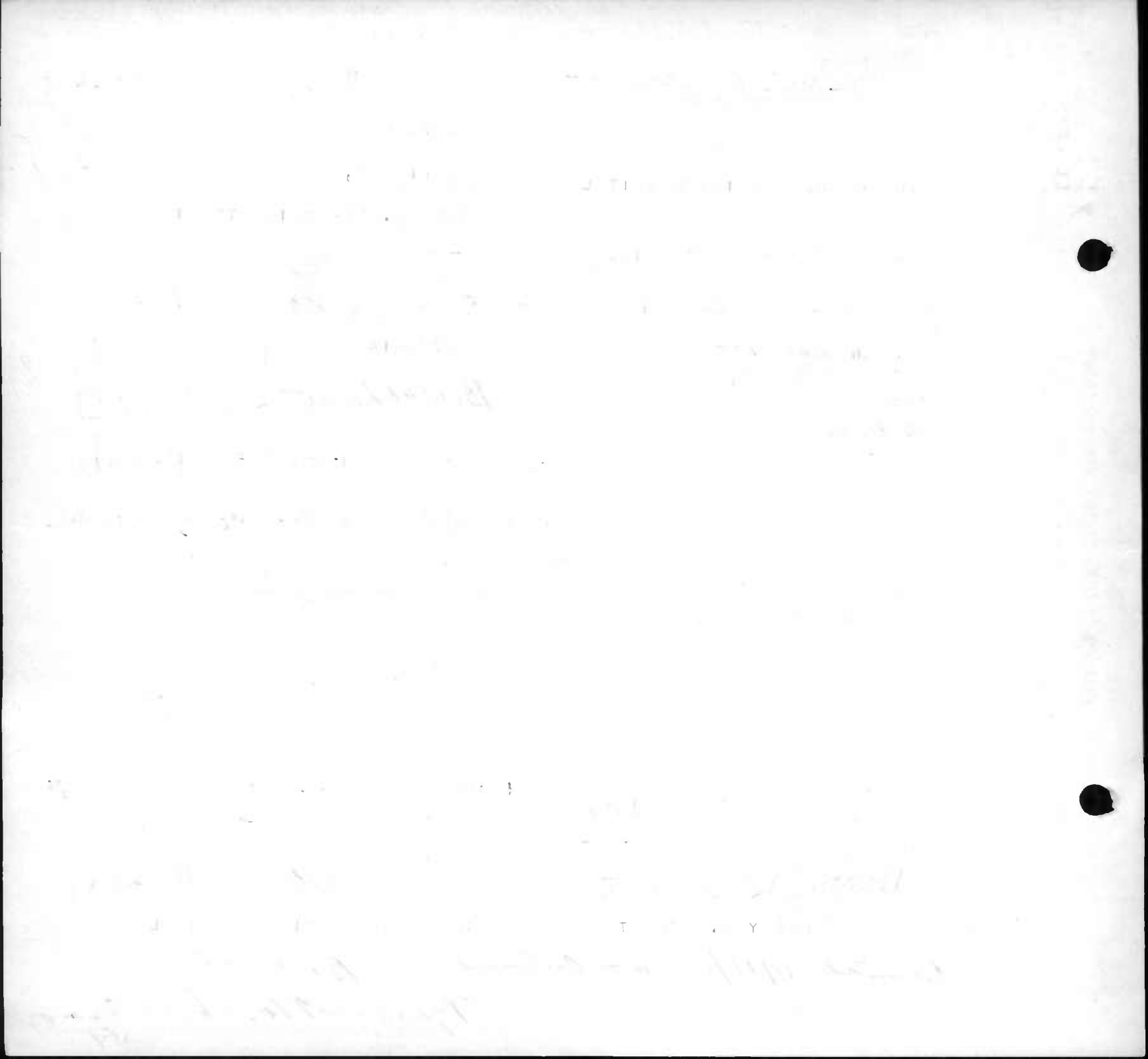
YIELD OF 100%

100% YIELD

100% YIELD

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

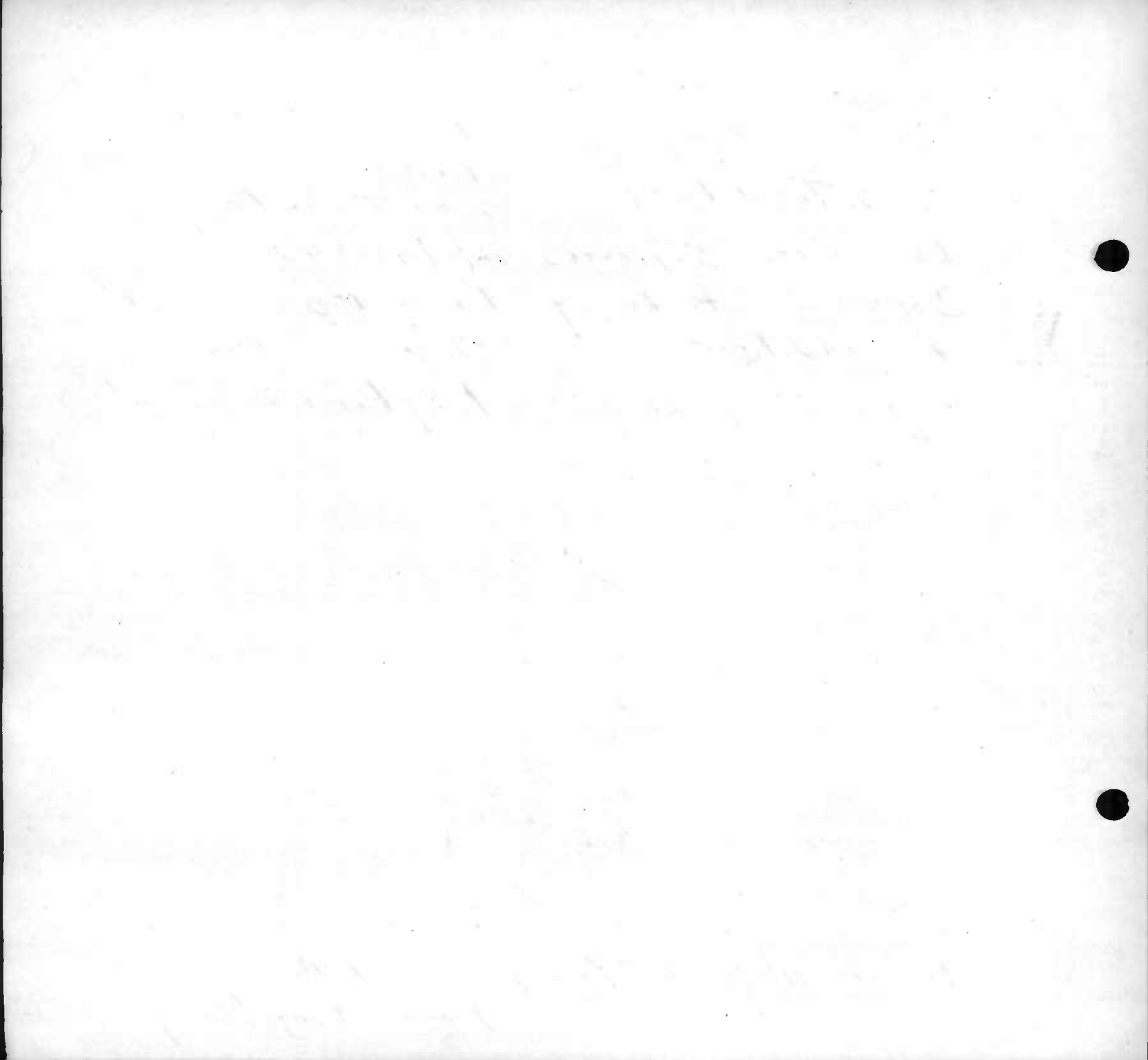
L-230		67 11024		BALTIMORE CITY HEALTH DEPT.		67 11024	
BIRTH NO.				CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>SQUIRE A. LOCKETT</b>			
2. DATE AND HOUR OF DEATH <b>11/12/67</b>				1:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE,</b> D. STREET ADDRESS (If rural, give location) <b>1619 W. FRANKLIN STREET</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>8-7-04</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CONTRACTOR</b>		11. BIRTHPLACE (State or foreign country) <b>RICHMOND VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN LOCKETT</b>				14. MOTHER'S MAIDEN NAME <b>PARTHEMIA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>BERTHA LOCKETT 5737 ROCKSPRING Rd</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY FAILURE</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>METASTATIC SARCOMA (LIPS)</b>				<b>3 YEARS</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10/17</b> 19 <b>67</b> to <b>11/12</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11/12</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Harry K. Genant</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/12/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>HARRY K. GENANT</b>				23D. ADDRESS M.D. <b>THE JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/17/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>m + Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 17 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbanks</b>		25C. FUNERAL DIRECTOR <b>Thurman P. Hayes</b>		ADDRESS <b>638 N. Gilman</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-520		BALTIMORE CITY HEALTH DEPARTMENT		67 11025	
BIRTH NO.		67 11025		Registered No.	
M.E. CASE NO.		67 11025		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		GERALDINE JONES		2. DATE AND HOUR OF DEATH 11-15-1967 2:00 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY		5. CITY OR TOWN (If outside city limits, write RURAL and give town) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 02302 TIOGA PKWY		C. CITY OR TOWN (If outside city limits, write RURAL and give town) BALTIMORE		D. STREET ADDRESS (If rural, give location) 2302 TIOGA PKWY	
5. SEX F	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED	8. DATE OF BIRTH 12/1/1920	9. AGE (In years lost birthday) 46	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10B. KIND OF BUSINESS OR INDUSTRY Put Family	11. BIRTHPLACE (State or foreign country) BALTO MD	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Kent		14. MOTHER'S MAIDEN NAME Clara Summons			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.		16. SOCIAL SECURITY NO. 215-16-7302	17. INFORMANT Betty Pierco 2302 Tioga Pkwy.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I		CAUSE OF DEATH (A) Acute myocardial infarction DUE TO (B) Antecedent causes DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 10 min. 2 yrs.	
19. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 15 1966 to Nov 15 1967, that (I) (we) last saw the deceased alive on Oct 26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Roland T. Smoot		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/16/67	
23C. PHYSICIAN'S NAME (Type) ROLAND T. SMOOT		23D. ADDRESS M.D. 3817 Copley Rd. BALTO 15, MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/18/67	24C. NAME of CEMETERY or CREMATORY Mt Calvary		24D. LOCATION (City, town, or county) (State) Baltimore 21225	
25A. DATE REC'D BY HEALTH DEPT. NOV 17 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Mansueti & Hays 638 N. Gileman St	

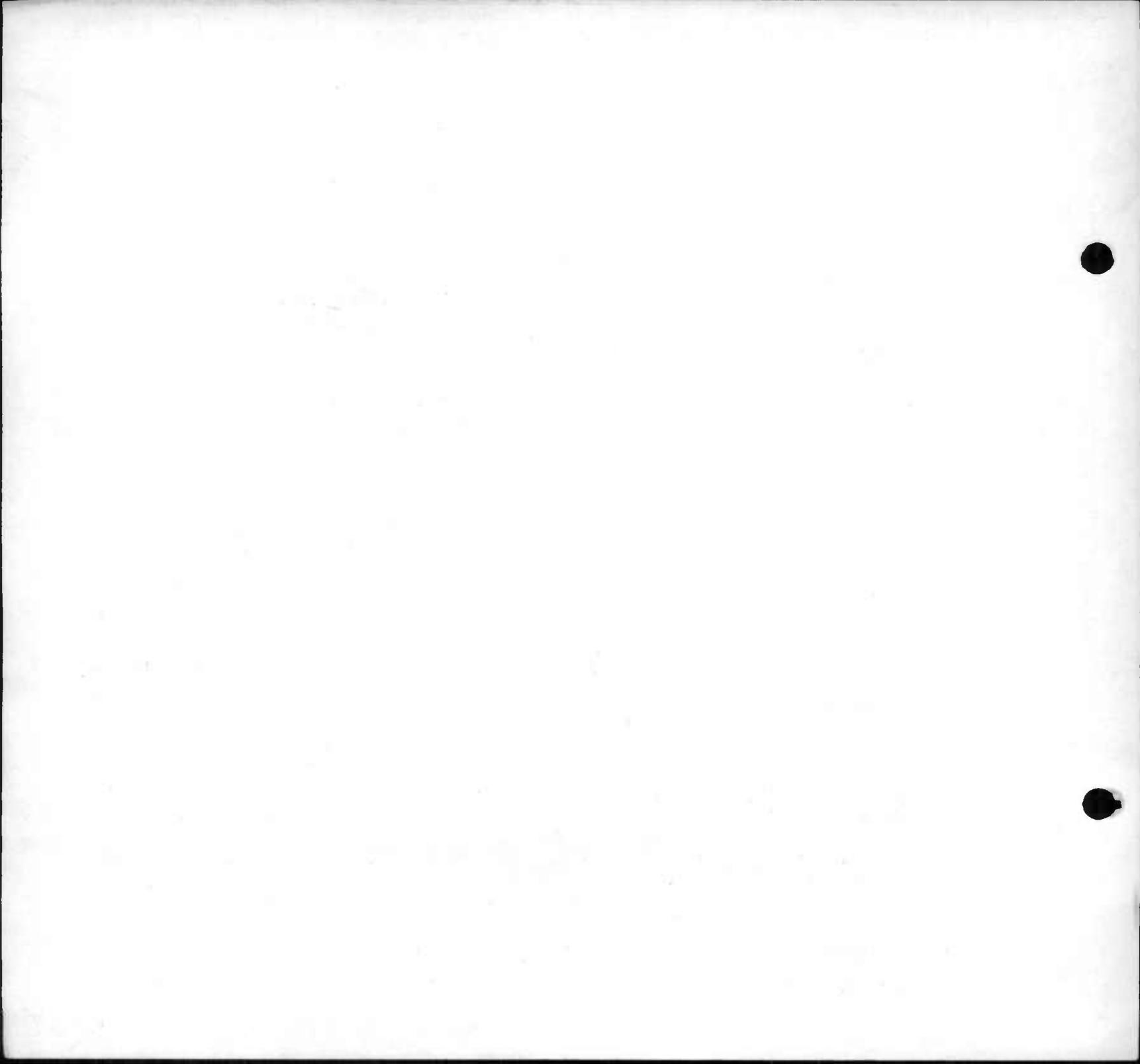




FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <b>67 11026</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>67 11026</b>	
1. NAME OF DECEASED (Type or Print) <b>Ella Brown</b>			2. DATE AND HOUR OF DEATH <b>Nov. 15 1967 1957pm</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>42 Sinai Hospital of Baltimore, Inc</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>15-13</b> D. STREET ADDRESS (If rural, give location) <b>4238 Towanda Ave.</b>		
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>12/17/1877</b>	9. AGE (In years last birthday) <b>89</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>U.S.A. S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>ESAW Marshall</b>			14. MOTHER'S MAIDEN NAME <b>Not Known</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Medical Record - Emergency Room Chart.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>420.1 I</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cardiogenic Shock</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Myocardial Infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>November 15 1967</b> to <b>November 15 1967</b> , that (I) (we) last saw the deceased alive on <b>957pm</b> 19 <b>11/15/67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/15/67</b>
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>11-18-67</b>	24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Pr.</b>		24D. LOCATION (City, town, or county) (State) <b>Arbutus, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 17 1967</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>KEBON FUNERAL HOME 1348 Calhoun St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 11027</u>	
BIRTH NO. <u>67 11027</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>PAYTON JAMES</u>		2. DATE AND HOUR OF DEATH <u>11-16-67</u> <u>3:30 A.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>LUTHERAN HOSPITAL</u>		A. STATE <u>B. COUNTY</u> <u>608 North Grantley St. Balto. Md</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give town) <u>Balto. Md</u>			
		D. STREET ADDRESS (If rural, give location) <u>Same as above.</u>			
5. SEX <u>M</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>8-30-95</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>		13. FATHER'S NAME <u>DAVID BEEDMAN PAYTON</u>		14. MOTHER'S MAIDEN NAME <u>HARPY AMANDA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>DAUGHTER SHANE</u>	
18. I <u>177X</u> I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <u>Pulmonary embolism</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Carcinoma of prostate</u>			
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>November 11</u> 19 <u>67</u> to <u>November 16</u> 19 <u>67</u> . that (I) (we) lost saw the deceased alive on <u>November 15</u> 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Emrique Rafael</u>				23B. DATE SIGNED <u>11-16-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>EMRIQUE RAFAEL</u>				23D. ADDRESS <u>Lutheran Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-19-67</u>		24C. NAME of CEMETERY or CREMATORY <u>Church Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Pick County, N.C.</u>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <u>Nov 17 1967</u>		25C. FUNERAL DIRECTOR ADDRESS <u>John Funeral Home 1348 Calhoun St.</u>			

My dear Mr. ...  
I have received your letter of the 12th inst. and am glad to hear that you are well.

I am very sorry to hear that you are not well. I hope you will soon be able to return to your work. I am sure you will be able to do so.

Yours very truly,  
[Signature]  
[Name]

Received of the ...  
[Signature]  
[Name]

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

DOROTHY WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD

November 15, 1967 3:16 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 73 N. Monastery - Balto, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

73 N. Monastery Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

10-7-10

9. AGE (In years  
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Williams

14. MOTHER'S MAIDEN NAME

MARTHA BROOKS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Elsie Williams SAME

18. 175.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Carcinoma of ovary with metastases  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 16, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11-19-67

23C. NAME OF CEMETERY or CREMATORY

Mt. Tabero Cem.

23D. LOCATION

(City, town, or county)

(State)

Anne Arundel Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

NOV 17 1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

ADDRESS

Kelson Funeral Home 1348 Calhoun St.

WILLIAM FOREST

WILLIAM FOREST

Baltimore

Answered

John Williams

Thomas Beck

John Williams

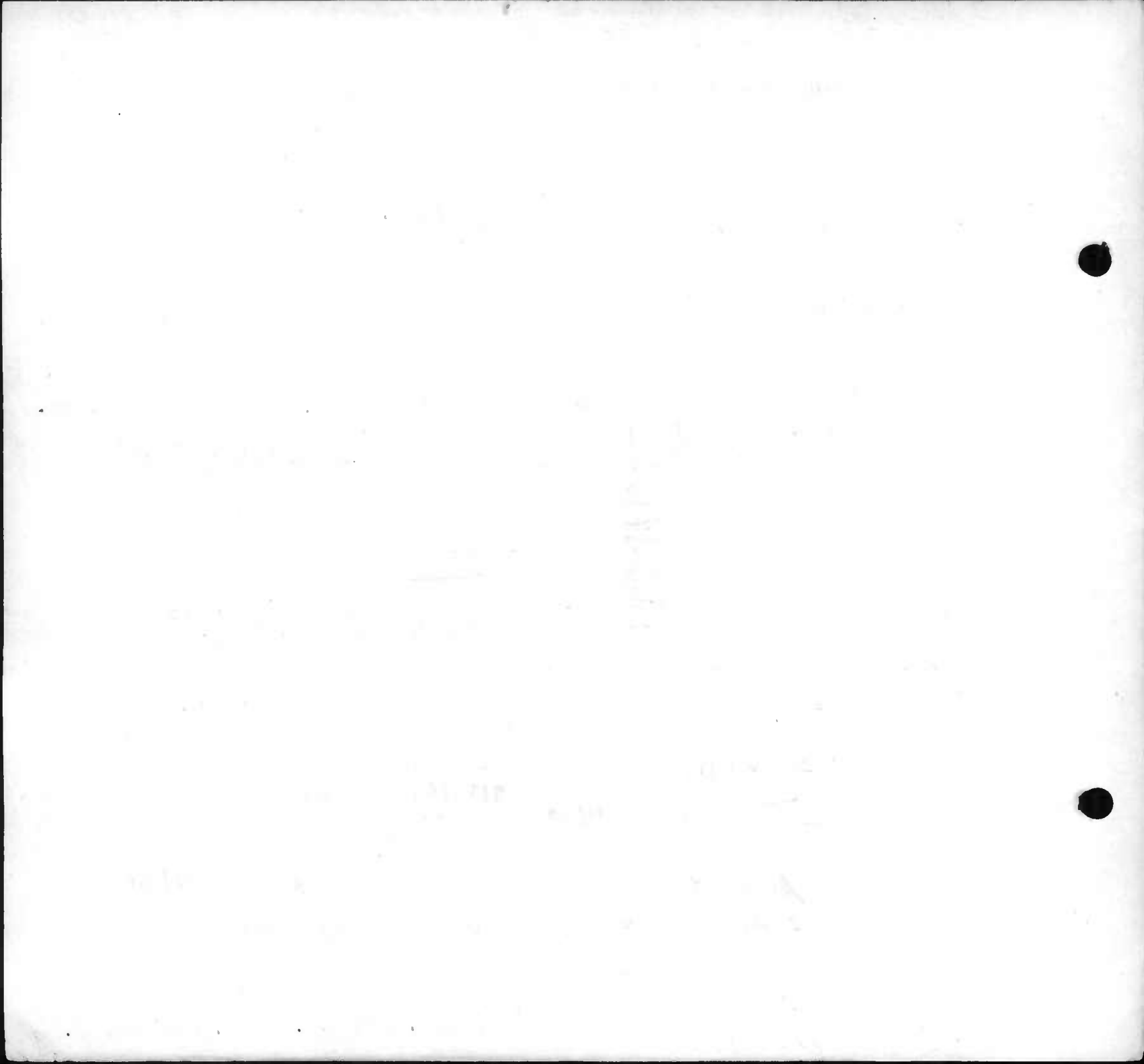
Location of every record

John Williams  
Wm. Forest  
Wm. Forest Co. Inc.  
Wm. Forest Co. Inc.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-650		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11029	
BIRTH NO. 67 11029		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARGARET E. DRANE		2. DATE AND HOUR OF DEATH 11/15/67 9:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
34 Bon Secours Hospital		2905 E. Jefferson St.			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)			
Balt - Md		2905 E. Jefferson Street		6-01	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 5-9-1884	9. AGE (In years last birthday) 83	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Baltimore Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Trott		14. MOTHER'S MAIDEN NAME Sarah McDevitt	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Reverend Joseph K. Drane 5704 Roland Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, leading rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) Submucous edema A.S.C.U.D. few			
		(B) Cardiovascular failure			
		(C) Septicemia Cardiovascular accident			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		FRACTURE of right hip			
19A. DATE OF OPERATION 09/26/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED fracture Rt hip		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) nursing home		21C. WHERE DID INJURY OCCUR? 2905 E. Jefferson St.	
21D. TIME OF INJURY (APPROX.) 9 24 67 1250 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell in way - bathroom	
22. I certify that (I) (this hospital) attended the deceased from 9/25/67 1967 to 11/15 19.67, that (I) (we) lost <u>saw</u> the deceased alive on 11/15 19.67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. A. BRAVO		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/15/67	
23C. PHYSICIAN'S NAME (Type) C. A. BRAVO		23D. ADDRESS BCN SECOURS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/18/1967		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 17 1967		25B. NAME OF REGISTRAR R. B. E. FARRER		25C. FUNERAL DIRECTOR ADDRESS John A. Moran Inc. 3000 E. Baltimore St.	





D-263

67 11030

BALTIMORE CITY HEALTH DEPARTMENT

67 11030

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

VIRGINIA DUKERT

2. DATE AND HOUR PRONOUNCED DEAD

November 12, 1967

2:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

222 East 39th Street

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)21 Seton  
99 6420 Reisterstown Road

(DOA)

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

MAY 2, 1930

9. AGE (In years  
last birthday)

37

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOSEPH B. LINTHICOM

14. MOTHER'S MAIDEN NAME

AGNES V. KAHLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

219-30-1155

17. INFORMANT

JOSEPH M DUKERT (HUSBAND)

ADDRESS

222 E. 39th St.  
BALT. MD.

18.

E 974 X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)(A) Asphyxia  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Hanging  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

(Partial)

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

hospital

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

6420 Reisterstown Road

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
11-12-67 about

1:50 P.m.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Hanged self

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒

DATE SIGNED

November 13, 1967

EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

ASSOCIATE MEDICAL EXAMINER ☐23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

Nov. 15, 1967

23C. NAME of CEMETERY or CREMATORY

BALTIMORE NATIONAL

23D. LOCATION

BALTIMORE MARYLAND

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 17 1967

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

RAYMOND J. CURRAN

ADDRESS

817 SCARLETT DR.

TOWSON, MD. 21204

N 991 X

67 11030

✓



W-4001

67 11031

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

67 11031

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MARGARET WALL

2. DATE AND HOUR OF DEATH

11-15-67 6:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

38 UNIV. HOSP

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

623 SARAH ANN ST

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

4-02

5. SEX

F

6. RACE

N

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

10-2-02

9. AGE (In years  
last birthday)

65

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ALEX MAIDEN

14. MOTHER'S MAIDEN NAME

JOSEPHINE

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

David Walls 623 Sarah Ann St.

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoarthritis, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHACUTE MASSIVE HEMORRHAGE 1 HOUR  
2° TO PERFORATION OF  
DESCENDING AORTA  
DURING NEPHRECTOMY  
FOR STAGHORN CALCULUS

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

11-15-67

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

STAGHORN CALC. YES

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 11-4 1967 to 11-15 1967.  
that (I) last saw the deceased alive on 11-15 1967 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (we) (did) view the body after death.

23A. SIGNATURE

Philip Miller Robinson

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

11-15-67

23C. PHYSICIAN'S  
NAME (Type)

23D. ADDRESS

M.D.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

Nov 20, 1967

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cemetery

24D. LOCATION

Westport (Baltimore) Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 17 1967

25B. NAME OF REGISTRAR

Robert E. Farley

25C. FUNERAL DIRECTOR

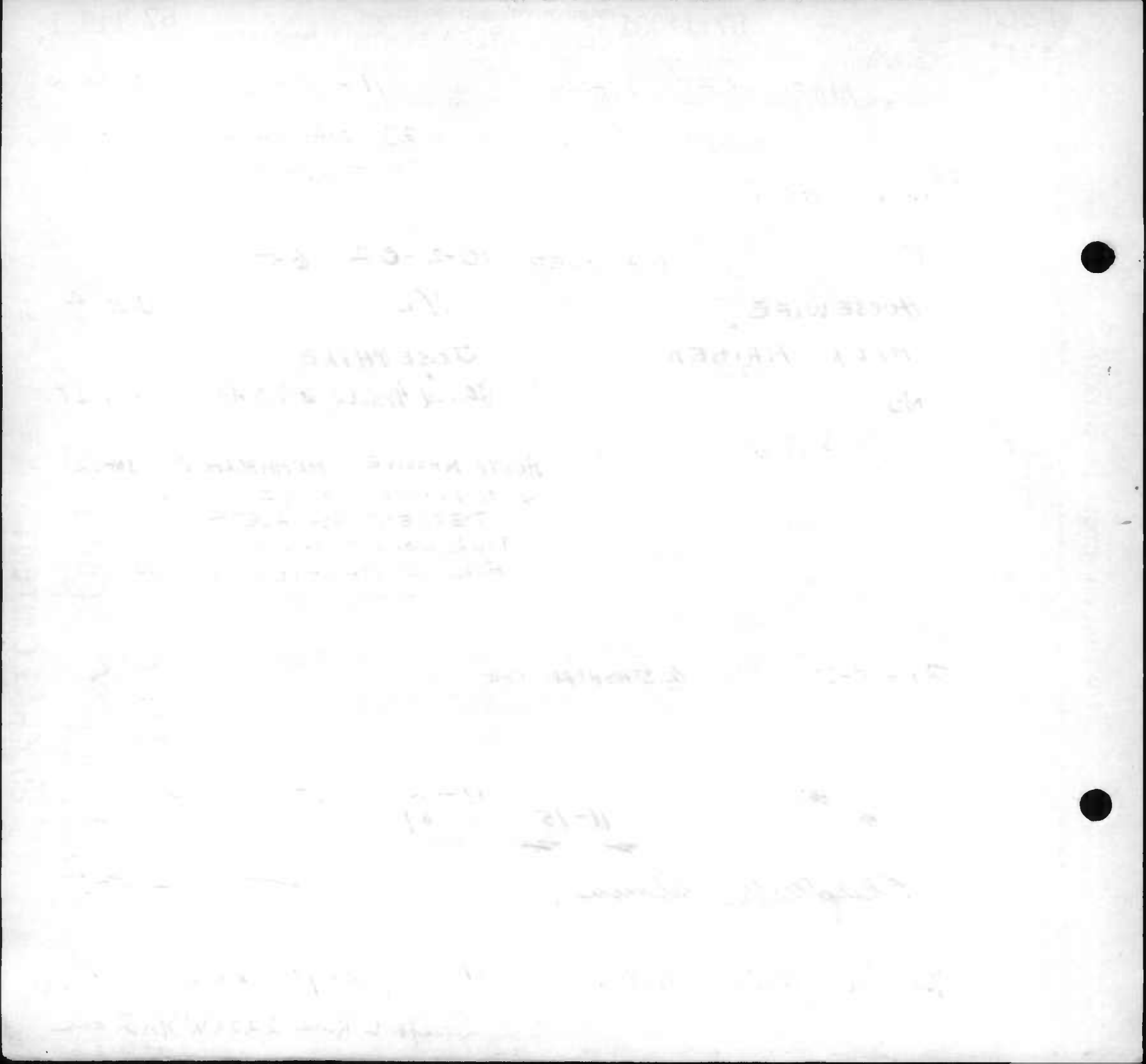
Joseph L. Russo 2222 W. North Ave

ADDRESS

21216

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



1  
P. 620

67 11032

BALTIMORE CITY HEALTH DEPARTMENT

67 11032

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES

PRICE, SR.

2. DATE AND HOUR PRONOUNCED DEAD

November 14, 1967

3:21 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

**CERTIFICATE AMENDED**  
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  
11-21-67

36 Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
Maryland  
B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

639 N. Fulton Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Luke

Price

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.  
240-26-0786

17. INFORMANT

ADDRESS

Mrs Bertha McCrimmons 923 Bennet Place

18. **E812.4**  
CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)  
**(A) Multiple Traumatic Injuries**  
DUE TO  
ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.  
(B) DUE TO  
(C) DUE TO  
II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION  
**2**  
19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED  
20A. AUTOPSY? (Yes or No)  
**Yes**  
20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?  
**Yes**  
21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.  
21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)  
**Street**  
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
**Carrollton St. - S. of Lexington St.**  
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)  
**11/13/67 9:00 P.m.**  
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒  
21F. HOW DID INJURY OCCUR?  
**Pedestrian struck by car**  
**18-02**

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐  
CHIEF MEDICAL EXAMINER ☐  
ACTUAL SIGNATURE **Werner U. Spitz, M.D.** M.D. ASSISTANT MEDICAL EXAMINER ☒  
EXAMINER'S NAME (Type) **Werner U. Spitz, M.D.** ASSOCIATE MEDICAL EXAMINER ☐  
DATE SIGNED  
**11/14/67**

23A. BURIAL CREMATION, REMOVAL (specify)  
**Burial**  
23B. DATE  
**11/18/67**  
23C. NAME OF CEMETERY or CREMATORY  
**St. Auburn Cemetery  
Baltimore National Cem.**  
23D. LOCATION (City, town, or county) (State)  
**Baltimore M d**

24A. DATE REC'D BY HEALTH DEPT.  
**NOV 17 1967**  
24B. NAME OF REGISTRAR  
**Robert E. Farley**  
24C. FUNERAL DIRECTOR  
**A Halstead**  
ADDRESS  
**1206 W North Ave**

11869.2 67 11032



1  
C-636

67 11033

BALTIMORE CITY HEALTH DEPARTMENT

67 11033

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

FRANK HIRST CARTER

2. DATE AND HOUR PRONOUNCED DEAD

November 15, 1967 6:50 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 710 Brune St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

710 Brune St.

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Married

8. DATE OF BIRTH

8/6/98

9. AGE (In years  
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Luther Carter

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

W W 1

16. SOCIAL  
SECURITY NO.

218-09-9214

17. INFORMANT

ADDRESS

Mrs Lafrieda Carter, same

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)  
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
m. WORK AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/20/67

23C. NAME OF CEMETERY or CREMATORY

National Cemetry

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

NOV 17 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

A Halstead 1206 W North Ave

ADDRESS

WILLIAM L. ROBERT

WILLIAM L. ROBERT

1954



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

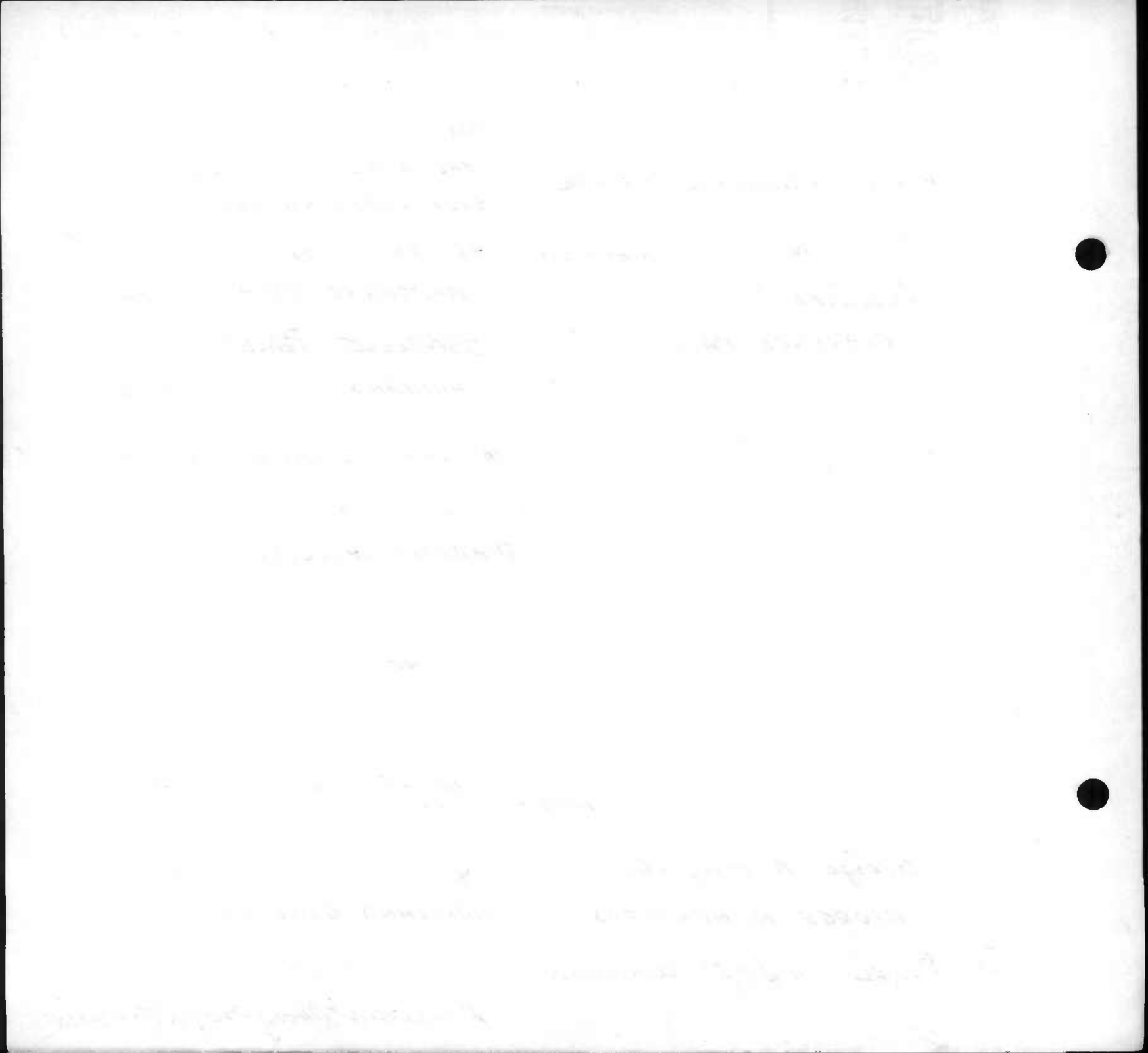
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11034</b>	
BIRTH NO. <b>67 11034</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Frank White</b>		2. DATE AND HOUR OF DEATH <b>November 16, 1967 3:05 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217</b>		A. STATE <b>Maryland</b> C. CITY OR TOWN <b>Baltimore</b> D. STREET ADDRESS <b>412 Myrtle Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>10/11/1907</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Ardella White- Wife 506 Poplar Grove St.</b>	
18. <b>165X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Carcinoma of Lung</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>November 15, 1967</b> to <b>November 16, 1967</b> , that (I) (we) last saw the deceased alive on <b>November 16, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>P. Chotikul</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-16-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Pochna Chbtikul</b>		23D. ADDRESS <b>1514 Division Street Baltimore, Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/20/67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>W. Roland Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore - Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 17 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>1712 W. W. Work</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-656		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. 67 11035		REGISTERED NO. 67 11035	
M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) CATHERINE E. TURNER		2. DATE AND HOUR OF DEATH 11/15/67 3:00 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore Co.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL 48		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21229 53-00	
		D. STREET ADDRESS (If rural, give location) 5424 CHANNING ROAD	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4/7/96
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 71
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CLARENCE PAUL		14. MOTHER'S MAIDEN NAME ISABELLE PEASE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT HUSBAND
		ADDRESS SAME	
18. 260 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) MYOCARDIAL INFARCTION 3 weeks DUE TO (B) CORONARY ART. DISEASE DUE TO (C) DIABETES MELLITUS	
INTERVAL BETWEEN ONSET AND DEATH			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10-24-1967 to 11-15-1967, that (I) (we) last saw the deceased alive on 11-15-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE George N. Agapitos		23B. DATE SIGNED 11-15-67	
23C. PHYSICIAN'S NAME (Type) GEORGE N. AGAPITOS		23D. ADDRESS MARYLAND GENERAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-18-1967	
24C. NAME OF CEMETERY or CREMATORY Woodlawn		24D. LOCATION (City, town, or county) (State) Woodlawn MD.	
25A. DATE REC'D BY HEALTH DEPT. NOV 17 1967		25B. NAME OF REGISTRAR G. E. Farley	
25C. FUNERAL DIRECTOR J. Howard Strong		25D. ADDRESS 307 N. North Ave	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

U-126		67 11036		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 67 11036	
BIRTH NO. 67 11036				2. DATE AND HOUR OF DEATH November 13, 1967 5-02 P.M.			
1. NAME OF DECEASED (Type or Print) Clarence D. Upsher Sr.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 2837 Woodbrook Ave				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2837 Woodbrook Ave			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Sept 1, 1882	9. AGE (In years last birthday) 85	If Under 1 Yr. Months Days Hours Min.	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY B & O Railroad	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME Laura ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mrs. Ambler Upsher 2837 Woodbrook Ave				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <i>Carcinoma of Prostate</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 mos.	
				(B) DUE TO			
				(C) DUE TO			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 11-9-1967 to 11-13-1967, that (I) (we) last saw the deceased alive on 11-13-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Percival C. Smith</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11-16-67	
23C. PHYSICIAN'S NAME (Type) Percival C. Smith			23D. ADDRESS M.D. 1709 Gwynns Falls Parkway				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11/17/67	24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Arbutus Balto. Co. Md			
25A. DATE REC'D BY HEALTH DEPT. NOV 17 1967		25B. NAME OF REGISTRAR <i>Robert E. Farley, MA</i>		25C. FUNERAL DIRECTOR Herbert E. Nutter		ADDRESS 3035 W. North Ave	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-400		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11037	
BIRTH NO. 67 11037		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>POWELL IDA VIRGINIA</i>		2. DATE AND HOUR OF DEATH <i>11-13-67 5:25 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institutions; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>13-04</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 SINAI Hosp.</i>		D. STREET ADDRESS (If rural, give location) <i>JENSEN 3502 Holmes Ave #17</i>			
5. SEX <i>Female</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>MARCH 31, 1870</i>	9. AGE (In years last birthday) <i>97 yrs.</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>MONTGOMERY, Co, Md</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>MARY JENSON</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>MRS. MARY HAYES 3502 HOLMES AVE</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>163X I</i> (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <i>Hemiparesis</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>20 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>CA Lung? pulmonary infarct?</i> DUE TO			
		(C) <i>ATRIAL Fibrillation ASCVD</i>		<i>5 yrs - 1 yr.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10-30</i> 19 <i>67</i> to <i>11-13-67</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>11-13</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Galvez</i> M.D.				23B. DATE SIGNED <i>11-13-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>EDITO C. GALVEZ</i> M.D.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>11/17/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>FAMILY LOT</i>	
24D. LOCATION (City, town, or county) <i>DAISY</i>		24E. LOCATION (State) <i>MARYLAND</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 17 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Galvez</i>		25C. FUNERAL DIRECTOR ADDRESS <i>HERBERT E. NUTTEN 3035 W. NORTH AVE</i>	

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THE BODY OF ELIZABETH WILSON HAS BEEN RELEASED AS NON-MED BY DR PALMUNO OF THE M.F. FUNERAL DIRECTOR. IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
W-425		67 11038		67 11038	
BIRTH NO.					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>Wilson, Elizabeth</i>			2. DATE AND HOUR OF DEATH <i>11-11-67 11:45 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 Johns Hopkins Hospital</i>			A. STATE <b>MARYLAND</b>		
(If not in hospital or institution, give street address or location)			B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		
			D. STREET ADDRESS (If rural, give location) <b>1321 MADISON AVE</b>		
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b>	8. DATE OF BIRTH <b>7-2-01</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Pvt. Family</b>		11. BIRTHPLACE (State or foreign country) <b>Lancaster Co. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>THOMAS MATTHEWS</b>		
14. MOTHER'S MAIDEN NAME <b>CARRIE THOMAS</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <b>216-36-8361</b>			17. INFORMANT ADDRESS <b>-Marie Johnson -2908 Presbury St.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>199.2 I</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Terminal carcinoma</b>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-11-67</b> to <b>11-11-67</b> that (I) (we) last saw the deceased alive on <b>11-11-67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>David S. Fedson</i>				23B. DATE SIGNED <b>11-11-67</b>	
23C. PHYSICIAN NAME (Type) <b>DAVID FEDSON</b>				23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/18/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Carver Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Laurel Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 17 1967</b>			
25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Herbert E. Nutter-3035 W. North Ave.</b>			

James H. Brown

Robert J. Anderson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPT.		Registered No.	
67 11039		CERTIFICATE OF DEATH		67 11039	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
BARBARA M. JESSEE		Nov. 17, 1967 6:35 AM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  48 MARYLAND GENERAL HOSP BALTO MD		A. STATE MD			
		B. COUNTY BALTO.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO			
		D. STREET ADDRESS (If rural, give location) 3501 CLIFTON AVE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH JUNE 29, 1907	9. AGE (In years last birthday) 60	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOK BINDER		10B. KIND OF BUSINESS OR INDUSTRY ALBRECHT CO.		11. BIRTHPLACE (State or foreign country) BALTO MD	
13. FATHER'S NAME JOHN BIGGS		14. MOTHER'S MAIDEN NAME CATHERINE LINK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-249058		17. INFORMANT HOSP. CHART + ALFRED JESSEE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  162.1 I ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 10/17		CAUSE OF DEATH (A) DUE TO BRONCHOGENIC CARCINOMA (B) DUE TO 2 metastasis (C) _____			
19A. DATE OF OPERATION 10/17/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from 10/6/67 19 to 10/17/67 19, that (I) (we) last saw the deceased alive on 10/16/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jeffrey Stier M.D.				23B. DATE SIGNED 11/17/67	
23C. PHYSICIAN'S NAME (Type) JEFFREY STIER		23D. ADDRESS MD GEN HOSP BALTO. MD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/20/67		24C. NAME OF CEMETERY or CREMATORY CREST LAWN CEMETERY	
				24D. LOCATION (City, town, or county) (State) RT # 40 WEST MD	
25A. DATE REC'D BY HEALTH DEPT. NOV 17 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR THE DIPPEL BROS INC 1800 E LOMBARD ST.	

1951

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MD BALTO.

BALTO

General

3501 CLIPMONT AVE

BALTO MD

June 21st 60

MARRIED

W

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USA

BALTO MD

ALBERT CO.

Bank Branch

CATHERINE LINK

John B. Gies

24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

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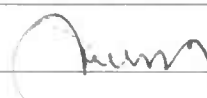
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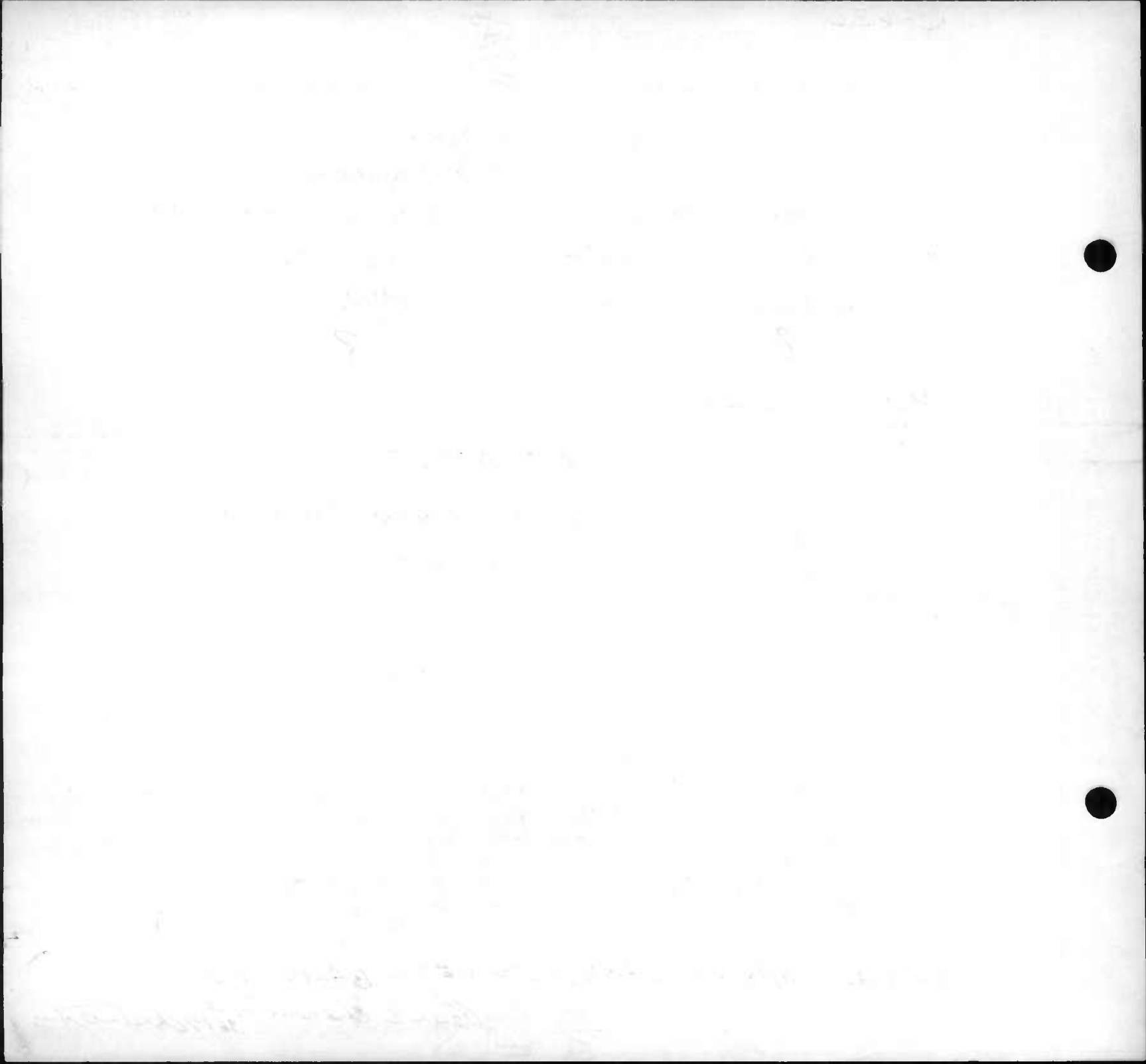
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-620		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11040	
BIRTH NO. 67 11040		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William Cross -		2. DATE AND HOUR OF DEATH Nov - 15 - 67 - 3.20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore - 26-10	
FULL NAME OF HOSPITAL OR INSTITUTION 49 North Charles Hospital -		D. STREET ADDRESS (If rural, give location) 112 N. Clinton St.			
5. SEX M	6. RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widow -	8. DATE OF BIRTH 3-15-92	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) light watchman.		10B. KIND OF BUSINESS OR INDUSTRY retired -		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-03-3424		17. INFORMANT ADDRESS Hospital records -	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I A.S.H.D.		CAUSE OF DEATH B. DUE TO Circulatory Collapse		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		C. DUE TO Myocardial Infarct.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No -	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 15 1967 to Nov. 15 1967, that (I) (we) last saw the deceased alive on Nov. 15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Paul E. Chenoweth		23D. ADDRESS M.D. 3617 Chestnut Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/18/67		24C. NAME OF CEMETERY OR CREMATORY LAKEVIEW MEM.	
24D. LOCATION BALTO. MD		25A. DATE REC'D BY HEALTH DEPT. NOV 17 1967		25B. NAME OF REGISTRAR Paul E. Chenoweth	
25C. FUNERAL DIRECTOR Paul E. Chenoweth		25D. ADDRESS 3617 Chestnut Ave.			



BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CHRISTINE DAY

2. DATE AND HOUR PRONOUNCED DEAD

November 15, 1967 12:25 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1331 W. 41st. St.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

2/6/00

9. AGE (In years  
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

SEAMSTRESS

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MO.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

220-30-354

17. INFORMANT

Stanley Day 1331 W. 41st St.

ADDRESS

18. E 816.4

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Subdural Hemorrhage  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Reistertown Rd. &amp; Northern Pkwy.

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

10 1 67 10:10p.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subject in auto-auto collision (driver)

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

November 15, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

11/18/67

23C. NAME OF CEMETERY or CREMATORY

CONRAINE

23D. LOCATION

(City, town, or county)

(State)

BALTO. MD.

24A. DATE REC'D BY HEALTH DEPT.

NOV 17 1967

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

Paul E. Charnow

ADDRESS

3617 Chestnut Ave.

WILLIAM H. ROGGE

VALLEY HARBOR

2/1/20  
NO. 1

MAILED

RECEIVED

See record by 121-1-1

Postmaster's Receipt

Postage

1/10/20



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-120		67 11042		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11042	
M.E. CASE NO.				CERIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>WARREN T. DAVIS</b>				2. DATE AND HOUR OF DEATH <b>NOV. 14, 1967 2:50 P. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE UNION MEMORIAL HOSPITAL</b> <b>44</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>12-03</b> D. STREET ADDRESS (If rural, give location) <b>2833 ST. PAUL</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWER</b>	8. DATE OF BIRTH <b>09-26-92</b>	9. AGE (In years lost birthday) <b>75</b>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NOT KNOWN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>W. VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>	
13. FATHER'S NAME <b>ALBERT G. DAVIS (D)</b>				14. MOTHER'S MAIDEN NAME <b>ALICE CONLEY (D)</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-17-0324</b>		17. INFORMANT <b>CHARLOTTE DAVIS</b>		ADDRESS <b>PHONE 243-6009</b>	
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary infection</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Pulmonary infection</b> DUE TO (B) <b>Coronary Heart Failure</b> DUE TO (C) <b>Arteriosclerotic Cardiac Vasomotor Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 months duration</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (he) (this hospital) attended the deceased from <b>11-08-67</b> 19 to <b>11-14-67</b> 19 that (he) (we) last saw the deceased alive on <b>11-14-67</b> 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Cesar F. Climaco</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-14-67</b>	
23C. PHYSICIAN'S NAME (AP) <b>CESAR F. CLIMACO</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/17/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>LODGE PARK</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 17 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Paul E. Chenoweth</b>		ADDRESS <b>3617 Chestnut Ave.</b>	

WALTER L. DAVIS

WIFE - ALICE

THE UNION LEAGUE, BALTIMORE

1833 ST PAUL

01-16-12

WIFE - ALICE

RETIRED

W. W. DAVIS

ALBERT G. DAVIS (D)

ALICE CORNELIA

CHARLOTTE DAVIS

Recovering infant

Carriage and horse

Unimpaired, but somewhat

11-18-12

11-18-12

11-18-12

Gen & Clara

CEASE & DESIST

THE UNION LEAGUE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

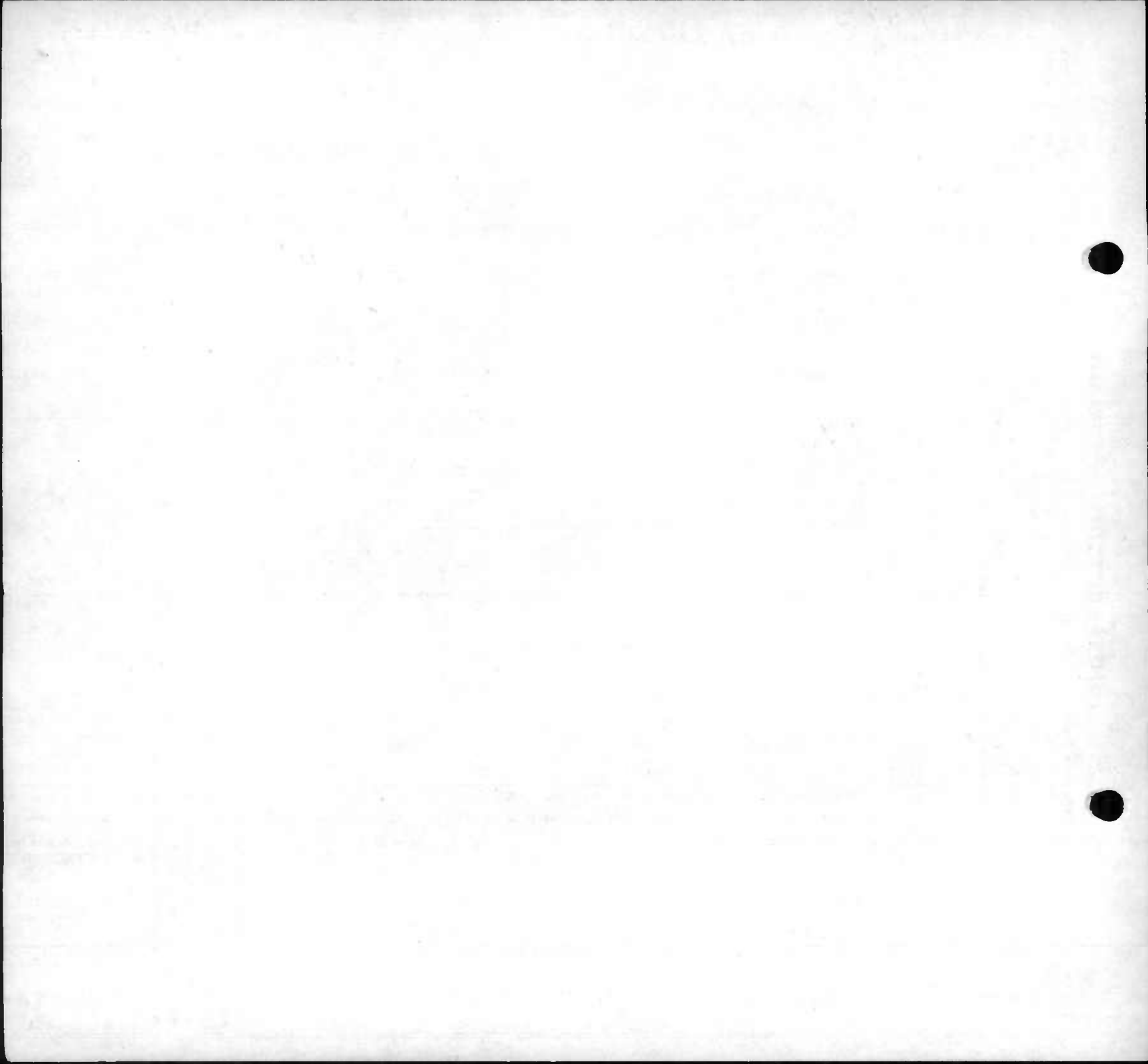
<p><b>67 11044</b> <b>CERTIFICATE OF DEATH</b></p>		<p>Registered No. <b>67 11044</b></p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print) <i>Emilia Lesniewski</i></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <i>11-15-67</i></p>	
<p><b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i></p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>001528 LaTrobe Park Terrace</i></p>		<p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1528 LaTrobe Park Terrace</i></p>	
<p><b>5. SEX</b> <i>F</i></p>	<p><b>6. RACE</b> <i>W</i></p>	<p><b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</b> <i>Widowed</i></p>	<p><b>8. DATE OF BIRTH</b> <i>8-15-92</i></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Housewife</i></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> —</p>	<p><b>9. AGE</b> (In years last birthday) <i>75</i></p>
<p><b>11. BIRTHPLACE</b> (State or foreign country) <i>Poland</i></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U. S. A.</i></p>	
<p><b>13. FATHER'S NAME</b> <i>Anthony Czastkiewicz</i></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <i>Un Known</i></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i></p>		<p><b>16. SOCIAL SECURITY NO.</b> —</p>	<p><b>17. INFORMANT</b> <i>Mrs. Irene Szytko</i></p>
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>443X I Hypertensive cardi-vascular disease</i></p>		<p><b>CAUSE OF DEATH</b> <i>coronary insufficiency</i></p>	
<p><b>19. DATE OF OPERATION</b> <i>0</i></p>		<p><b>20. AUTOPSY? (Yes or No)</b> <i>No</i></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/></p>	
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p><b>21F. HOW DID INJURY OCCUR?</b></p>		<p><b>21G. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from <i>May</i> 19<i>64</i> to <i>Oct. 15</i> 19<i>67</i>, that (I) (<del>we</del>) last saw the deceased alive on <i>Oct 15</i> 19<i>67</i> and that in (my) (<del>our</del>) opinion death occurred on the date and hour and from the causes stated above. (I) (<del>we</del>) (<del>did</del>) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <i>Romulo V. Gao</i></p>		<p><b>23B. DATE SIGNED</b> <i>11/16/67</i></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <i>Romulo V. Gao</i></p>		<p><b>23D. ADDRESS</b> <i>707 E. Fort Ave. B. Md. Md.</i></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <i>Burial</i></p>	<p><b>24B. DATE</b> <i>11/20/67</i></p>	<p><b>24C. NAME OF CEMETERY or</b> <i>Holy Rosary Cemetery</i></p>	<p><b>24D. LOCATION</b> (City, town, or county) (State) <i>Baltimore, Maryland</i></p>
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <i>NOV 17 1967</i></p>		<p><b>25B. NAME OF REGISTRAR</b> <i>Robert E. Faldut</i></p>	
<p><b>25C. FUNERAL DIRECTOR</b> <i>Charles L. Stevens Funeral Home, Inc.</i></p>		<p><b>ADDRESS</b> <i>1501 East Fort Avenue</i></p>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-575 B-552 67 11045		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11045	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <i>Salvatore Benvenge</i>			2. DATE AND HOUR OF DEATH <i>11-16-67 100 P</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hosp</i>			A. STATE <i>MD</i> B. COUNTY <i>-</i>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto 26-10</i>		
			D. STREET ADDRESS (If rural, give location) <i>151 S. Bouldin St 21224</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, (NEVER MARRIED) WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>6-17-54</i>	9. AGE (In years last birthday) <i>13</i>	10. CITIZEN OF WHAT COUNTRY? <i>USA</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balto - MD</i>	
13. FATHER'S NAME <i>Frank C. Benvenge</i>			14. MOTHER'S MAIDEN NAME <i>Bernardine Super</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Father</i>	
				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>201X I Hodgkins Disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>13 mos</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10-25-67</i> 19 to <i>11-16-67</i> 19, that (I) (we) last saw the deceased alive on <i>11-16-67</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Chester C Collins MD</i>				23B. DATE SIGNED <i>11-16-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Chester C Collins</i>				23D. ADDRESS <i>M.D. Mercy Hosp</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>11/20/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>St. Stanislaus</i>	
				24D. LOCATION (City, town, or county) (State) <i>Balto. MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 17 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR <i>Joseph N. Zannone</i>	
				ADDRESS <i>263 S. Conkling St</i>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print) <b>TAYLOR, LAWRENCE EDWARD</b>		2. DATE AND HOUR OF DEATH <b>11/16/67 8:45 A M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>27 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>15-02 1617 N. Appleton Street</b>	
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>8/2/92</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>	9. AGE (In years last birthday) <b>75</b>
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Van Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Lettie Kendall</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes 7/29/18 - 7/3/19</b>		16. SOCIAL SECURITY NO. <b>215-09-5517</b>	
17. INFORMANT <b>VA Hospital Records</b>		ADDRESS <b>Baltimore, Maryland 21218</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) <b>450.0 I Arteriovascular Disease</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II Diffused pulmonary fibrosis Cirrhosis of liver</b>			INTERVAL BETWEEN ONSET AND DEATH <b>undetermined</b>
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (✓) (this hospital) attended the deceased from <b>November 8th 19 67 to November 16th 19 67</b> , that (✓) (we) lost saw the deceased olive on <b>November 16th 19 67</b> and that in (✓) (our) opinion death occurred on the date and hour and from the causes stated above. (✓) (We) (did) (not) view the body after death.			
23A. SIGNATURE <b>Richard J. Owellen</b>			23B. DATE SIGNED <b>11/17/67</b>
23C. PHYSICIAN'S NAME (Type) <b>RICHARD J. OWELLEN</b>			23D. ADDRESS <b>VA Hospital Baltimore, Maryland 21218</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>11/21/67</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 17 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>		ADDRESS <b>3477 Schuyler St</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11047</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>C-632</b></span> <span><b>67 11047</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <b>67 11047</b></span> <span>M.E. CASE NO. <b>67 11047</b></span> </div>					
<b>1. NAME OF DECEASED</b> (Type or Print) <b>Burney Carter</b>			<b>2. DATE AND HOUR OF DEATH</b> <b>11-15-67 10:05 p.m.</b>		
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>39 Provident Hospital Inc; 1514 Division Street Baltimore, Maryland 21217</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>Baltimore</b> B. COUNTY <b>Maryland</b> <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <b>14-01</b> <b>D. STREET ADDRESS</b> (If rural, give location) <b>Bolton Hill Nursing Home 7</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. RACE</b> <b>Negro</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (specify) <b>Widow</b>	<b>8. DATE OF BIRTH</b> <b>March 12, 1893</b>	<b>9. AGE</b> (In years last birthday) <b>75</b>	<b>10. If Under 1 Yr. Months; Days</b> <b>11. If Under 24 Hrs. Hours; Min.</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Longshoreman</b>			<b>11. BIRTHPLACE</b> (State or foreign country) <b>Hanover, Va.</b>		
<b>13. FATHER'S NAME</b> <b>Richard Carter</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Adeline Hill</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W.I</b>			<b>16. SOCIAL SECURITY NO.</b> <b>212-05-2259</b>		
<b>17. INFORMANT</b> <b>Christine Brooks- Rel- ?</b>			<b>ADDRESS</b> <b>1609 W. Lox. St. W17-4725</b>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>331X1</b>			<b>CAUSE OF DEATH</b> <b>(A) Cerebral Hemmhorage</b>		
<b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>?</b>		
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>					
<b>19A. DATE OF OPERATION</b> <b>none</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>-</b>		<b>20A. AUTOPSY?</b> (Yes or No) <b>No</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <b>No</b>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Approx.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from November 14, 1967 to November 15, 1967, that (I) (we) last saw the deceased alive on November 15, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>P. Chotikul M.D.</b>				<b>23B. DATE SIGNED</b> <b>11-16-67</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>POCHNA CHOTIKUL M.D.</b>				<b>23D. ADDRESS</b> <b>1514 Division Street Baltimore, Maryland</b>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24B. DATE</b> <b>11/20/67</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Balto. National Cem.</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>Balto. Md.</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>NOV 17 1967</b>		<b>25B. NAME OF REGISTRAR</b> <b>R. E. E. F. Adams</b>	
<b>25C. FUNERAL DIRECTOR</b> <b>Williams Funeral Home</b>		<b>ADDRESS</b> <b>399 N. Howard St.</b>			

Handwritten text, possibly a signature or name, located in the upper left quadrant.

Handwritten text, possibly a date or short phrase, located in the upper center.

Handwritten text, possibly a name or title, located in the upper left quadrant.

Handwritten text, possibly a name or title, located in the upper right quadrant.

Handwritten text, possibly a name or title, located in the upper left quadrant.

Handwritten text, possibly a name or title, located in the upper right quadrant.

Handwritten text, possibly a name or title, located in the center.

Handwritten text, possibly a name or title, located in the upper right quadrant.

Handwritten text, possibly a signature or name, located at the bottom center.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

RICHARD M. MC NEIL (McNeal)

2. DATE AND HOUR PRONOUNCED DEAD

November 12, 1967 12:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1836 Washington Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Nov. 12, 1938

9. AGE (In years  
last birthday)

28

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William McNeal

14. MOTHER'S MAIDEN NAME

Aliefair Cash

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Emma McNeal 1836 N. Washington St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Cerebrocranial injuries

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

11-11-67

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

Head injuries

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

In front of 8324 Belair Road

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
11-11-67 7:00 A.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Driver of auto which struck pole

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 13, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/17/67

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county) (State)  
Anne Arundel Cty., Md.

24A. DATE REC'D BY HEALTH DEPT.

NOV 17 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS  
Wm C March 928 E. North Ave.

WALLACE  
PROFESSOR

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11049

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ELEANORE DUNKLE

2. DATE AND HOUR PRONOUNCED DEAD

November 16, 1967 9:15 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1920 Lemmon St.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

JUNE 3, 1924 43

9. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

WAITRESS

10B. KIND OF BUSINESS OR INDUSTRY

Food Dispensing

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

?

Schultz

14. MOTHER'S MAIDEN NAME

McGrath

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

NONE

16. SOCIAL  
SECURITY NO.

218-20-1901

17. INFORMANT

ADDRESS

Calvin R. Dunkle 1920 Lemmon St.

18.

581.0 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Fatty Liver

(A) \_\_\_\_\_  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO

(C) \_\_\_\_\_

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATURE

Edward F. Wilson

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐EXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

November 17, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11-20-67

23C. NAME OF CEMETERY or CREMATORY

Meadowridge Memorial

23D. LOCATION

(City, town, or county)

Howard County

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

NOV 20 1967

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

GEO. L. Schwab Funeral Home  
Francis H. Miller 2101 Frederick Ave.

Received June 3, 1947 \$20.00  
from the Tennessee Valley Authority  
for the purchase of 20 shares of  
the Tennessee Valley Authority  
at \$1.00 per share.

PAID  
TO THE  
TREASURER  
OF THE  
STATE OF TENNESSEE  
JUN 3 1947

Received from the Tennessee Valley Authority  
for the purchase of 20 shares of  
the Tennessee Valley Authority  
at \$1.00 per share.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11050		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11050	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		BROWN CLARA		NOV 15 1967 7:20 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. SEX	
CERTIFICATE AMENDED 11-27-67 ST AGNES HOSPITAL		A. STATE MD B. COUNTY BALTIMORE 29 28-64		FEMALE WHITE	
6. RACE		7. MARRIED, NEVER MARRIED		8. DATE OF BIRTH	
WHITE		WIDOWED		8-16-97	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
Teletype Operator		Western Union		70	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		11. BIRTHPLACE (State or foreign country)	
FRANK B. Forrer		CALIE Humphrey		VA.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		217 01 1166 ST AGNES HOSPITAL CATON & WILKENS AVE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
465X 12 170X (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Respiratory Arrest. (B) Pulmonary Infarct. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Ca Left breast (treated).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from OCT 24 19 67 to NOV 15 19 67, that (I) (we) last saw the deceased alive on NOV 15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
A. MEJIA, M.D. A. MEJIA, M.D.				11-15-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
A. MEJIA, M.D.				CATON AND WILKENS AVE. BALTIMORE MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/18/67		Woodlawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 20 1967		Robert E. Jackson		Loring Byers	
				8728 Liberty Rd Randalltown Md	

ST. VERNER HOSPITAL

1000 N. 10TH ST.

MINNEAPOLIS, MN

5-10-67

50

5212 S. WILSON ST. W.

MINNEAPOLIS

11101 11th St. Verner Hospital, Dept. 1 & 2, Minn. Ave.

DATE: 11-27-67

AV.

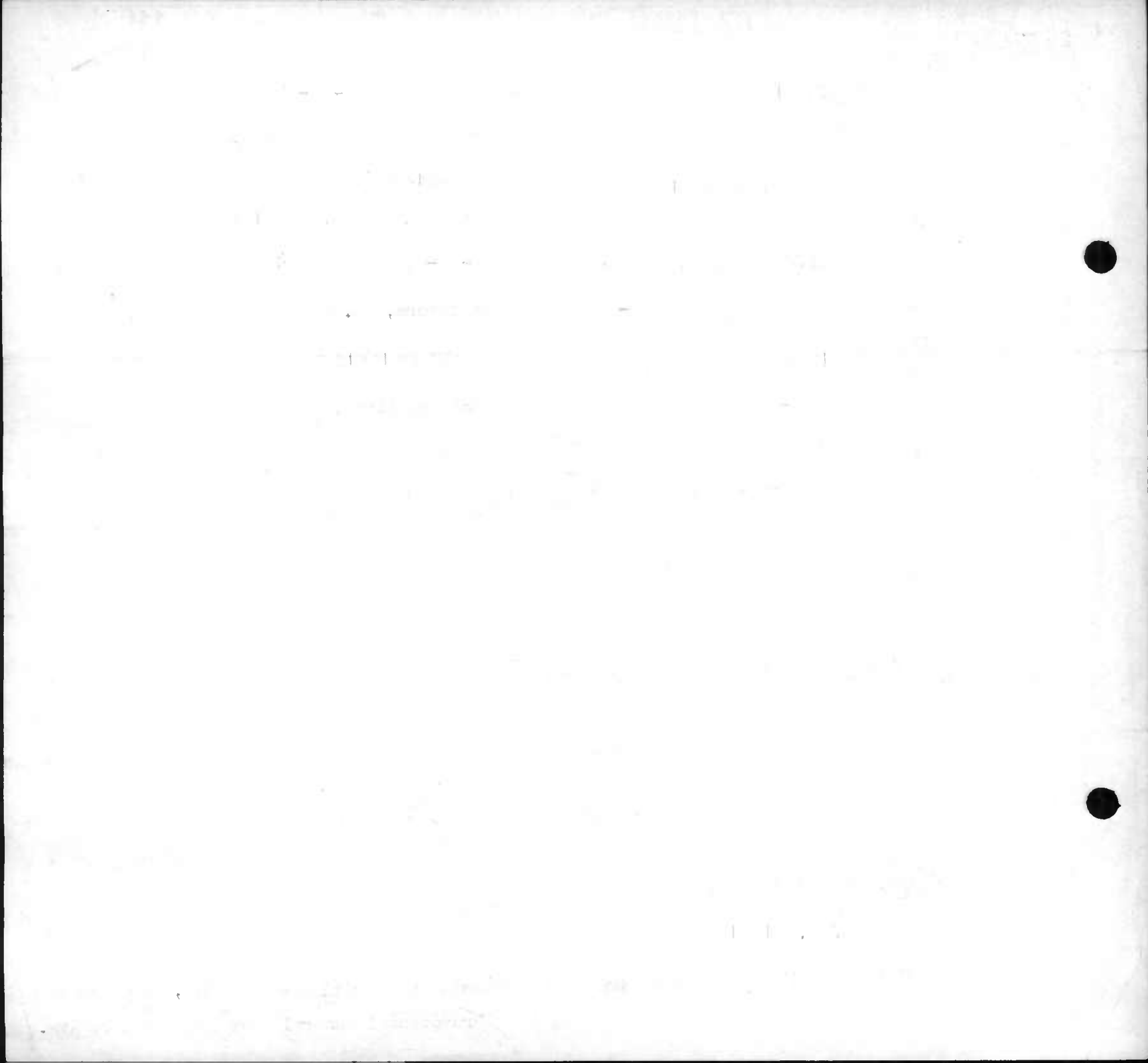
CYTON AND WILSONS AVE. DEPT. 1 & 2

11-27-67

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>63-23577</u> <u>67 11051</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67 11051</u>	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>DEREK WILSON</u>		2. DATE AND HOUR OF DEATH <u>11-15-67</u> <u>8 AM</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Essex (21)</u> D. STREET ADDRESS (If rural, give location) <u>1400 C BROWNING DRIVE</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>8-24-63</u>	9. AGE (In years last birthday) <u>4</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>RONALD WILSON</u>		14. MOTHER'S MAIDEN NAME <u>RENA WILLIS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Ronald Wilson, Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>754.7 I</u> <u>(a) Cause of pulmonary edema</u> <u>(b) pulmonary artery of the heart</u>		CAUSE OF DEATH <u>(a) Cause of pulmonary edema</u> <u>(b) pulmonary artery of the heart</u>		INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>11/2/67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>transplantation of heart</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from <u>10/30</u> 19 <u>67</u> to <u>11/15</u> 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11/15</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert S. Pitkin</u>		M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>11/15/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>ROBERT S. PITKIN</u>		23D. ADDRESS <u>Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/18/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u>	
24D. LOCATION <u>Baltimore County, Maryland</u>		24E. FUNERAL DIRECTOR <u>Bruzdzinski Funeral Home</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 20 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>			
25C. ADDRESS <u>1407 Eastern Ave.</u>					



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ANTHONY SCIACCA

2. DATE AND HOUR PRONOUNCED DEAD

November 15, 1967 4:20 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Pasadena

D. STREET ADDRESS (If rural, give location)

173 Meadow Rd.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec. 24, 1890

9. AGE (in years  
last birthday)

76 - 75 -

If Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Barber

10B. KIND OF BUSINESS OR INDUSTRY

Self-employed

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Sciacca

14. MOTHER'S MAIDEN NAME

Rose Sciacca

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWI

16. SOCIAL  
SECURITY NO.

217-32-8375

17. INFORMANT

Pietrina C. Sciacca - 173 Meadow Rd. - Pasadena

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Mercury Poisoning

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

173 Meadow Rd.

21D. TIME  
OF INJURY  
(APPROX.)

11 14 67

?

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Subject took mercury pills

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 15,

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11-20-67

23C. NAME of CEMETERY or CREMATORY

New Cathedral Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State) 1967

24A. DATE REC'D. BY HEALTH DEPT.

NOV 20 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

John C. Miller Inc. - 6415 Belair Rd. - 21206

ADDRESS

JOHN R. CAMPBELL

WILLIAM FORGE

WILLIAM FORGE

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WILLIAM FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 11053</u>	
BIRTH NO. <u>67 11053</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <b>NOVEMBER 17, 1967   2:45 A.M.</b>			
1. NAME OF DECEASED <b>SCHULTHEIS WALTER F.</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>ST AGNES HOSPITAL WILKENS AND CATON AVENUE BALTIMORE MARYLAND 21229</b> <span style="font-size: 2em; margin-left: 100px;">40</span>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>a.a.co</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>GLEN BURNIE 21061</b> D. STREET ADDRESS (If rural, give location) <b>1203 NOTTINGHAM DRIVE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>11/19/23</b>	9. AGE (in years last birthday) <b>44</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>	
13. FATHER'S NAME <b>WALTER F. SCHULTHEIS SR.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>212 22 0503</b>		17. INFORMANT ADDRESS <b>ST AGNES HOSPITAL WILKENS AND CATON AVE</b>	
18. <b>331 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Intercranial hemorrhage</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>NOVEMBER 15 1967</b> to <b>NOVEMBER 17 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>NOVEMBER 17 1967</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <del>XXXX</del> view the body after death.					
23A. SIGNATURE <b>S. Korbly</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11-17-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>S. KORBLY</b>		23D. ADDRESS M.D. <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVE.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/21/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>CEDAR HILL CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>GLEN BURNIE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 20 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>McGilly 237 Patapsco Ave</b>			

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11054				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11054	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>BARRON E. HOLCOMBE</b>				2. DATE AND HOUR OF DEATH <b>11-13-67</b>   <b>6:20 A M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>346 SOUTH CHESTER STREET</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>10-29-67</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JAMES HOLCOMBE</b>				14. MOTHER'S MAIDEN NAME <b>MARY PAYNE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. <b>420.1 I</b> <i>Probable</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b> (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>XX</del> (this hospital) attended the deceased from <b>FEBRUARY 9 19 66</b> to <b>NOVEMBER 11 19 67</b> , that (I) <del>XX</del> last saw the deceased alive on <b>NOVEMBER 13 19 67</b> and that in <del>XX</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>XX</del> (did) (di <del>XX</del> ) view the body after death.							
23A. SIGNATURE <b>K.E. Gilmore</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/13/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>K.E. GILMORE</b>				23D. ADDRESS M.D. <b>THE JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>11-14-67</b>		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) <b>L. (Baltimore)</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 20 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</b>			

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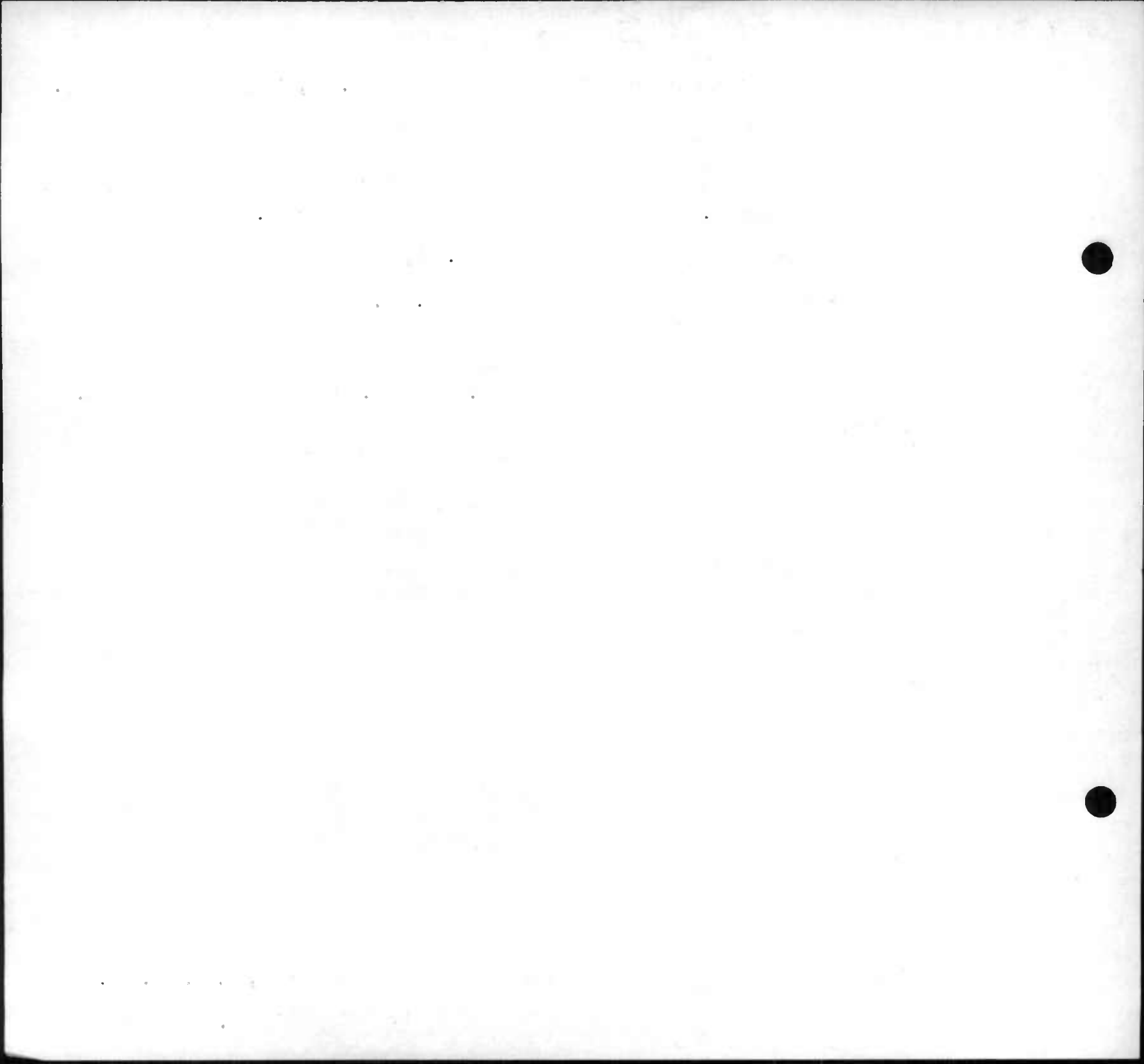
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FUNERAL DIRECTOR: IMPORTANT

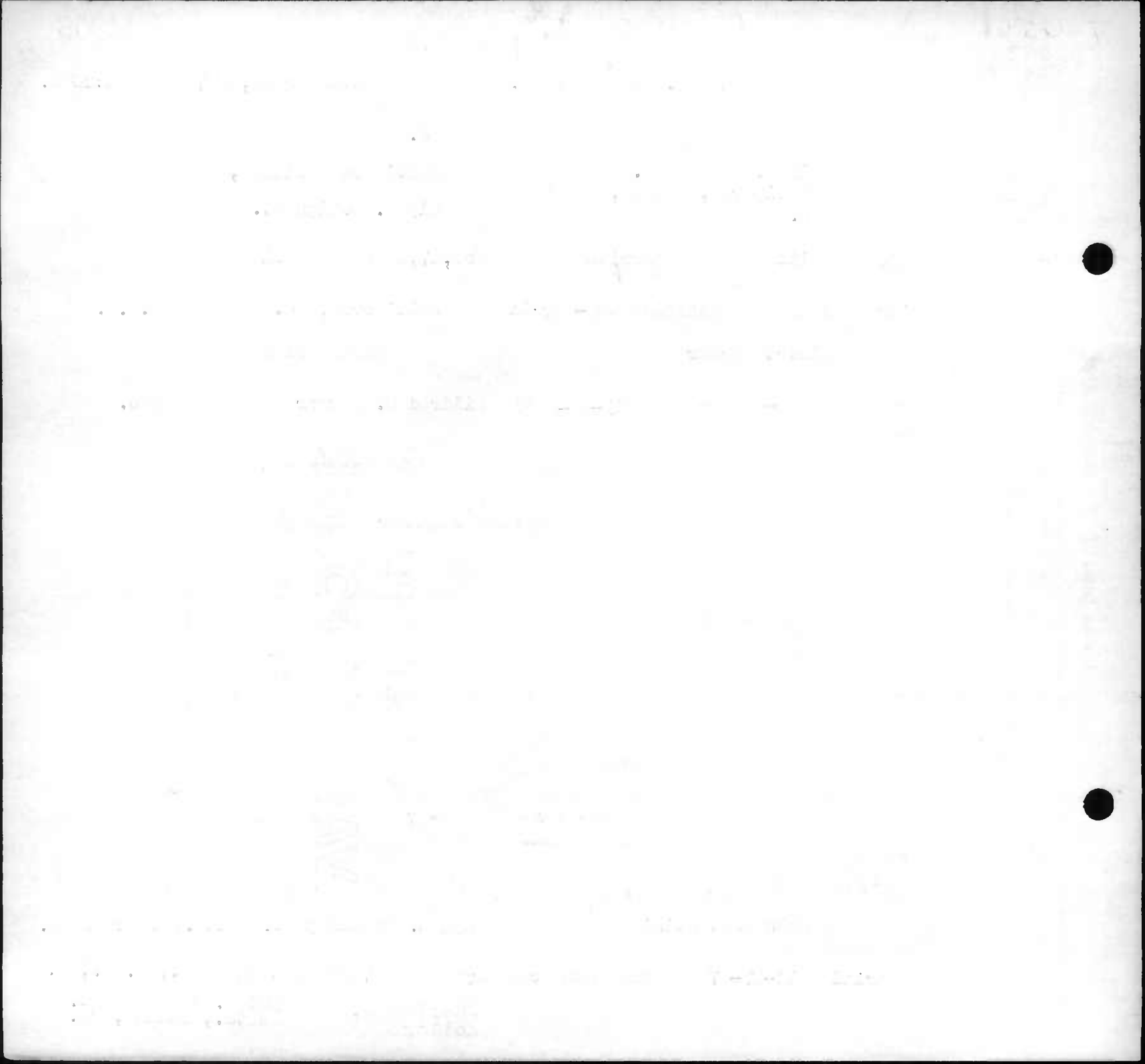
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11055</b>	
BIRTH NO. <b>67 11055</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Anna Margaret Giles</b>		2. DATE AND HOUR OF DEATH <b>Nov. 14, 1967</b> <b>4 P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>00 1635 Webster St.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1635 Webster St.</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Oct. 12, 1902</b>	9. AGE (In years last birthday) <b>65</b>	II Under 1 Yr. Months Days II Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>William Ripken</b>		14. MOTHER'S MAIDEN NAME <b>Annie Silberzahn</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mr. Louis F. Giles 1635 Webster St.</b>	
18. <b>430.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic cardiac Vascular Disease</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7-12-1967</b> to <b>11-14-1967</b> , that (I) (we) last saw the deceased alive on <b>11-14-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Blando V. How, M.D.</b>				23B. DATE SIGNED <b>11-17-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>M.D.</b>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11 18 67</b>		24C. NAME of CEMETERY or CREMATORY <b>Glen Haven</b>	
24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, A. A. Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Mc Cully</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>130 E. Fort Ave</b>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

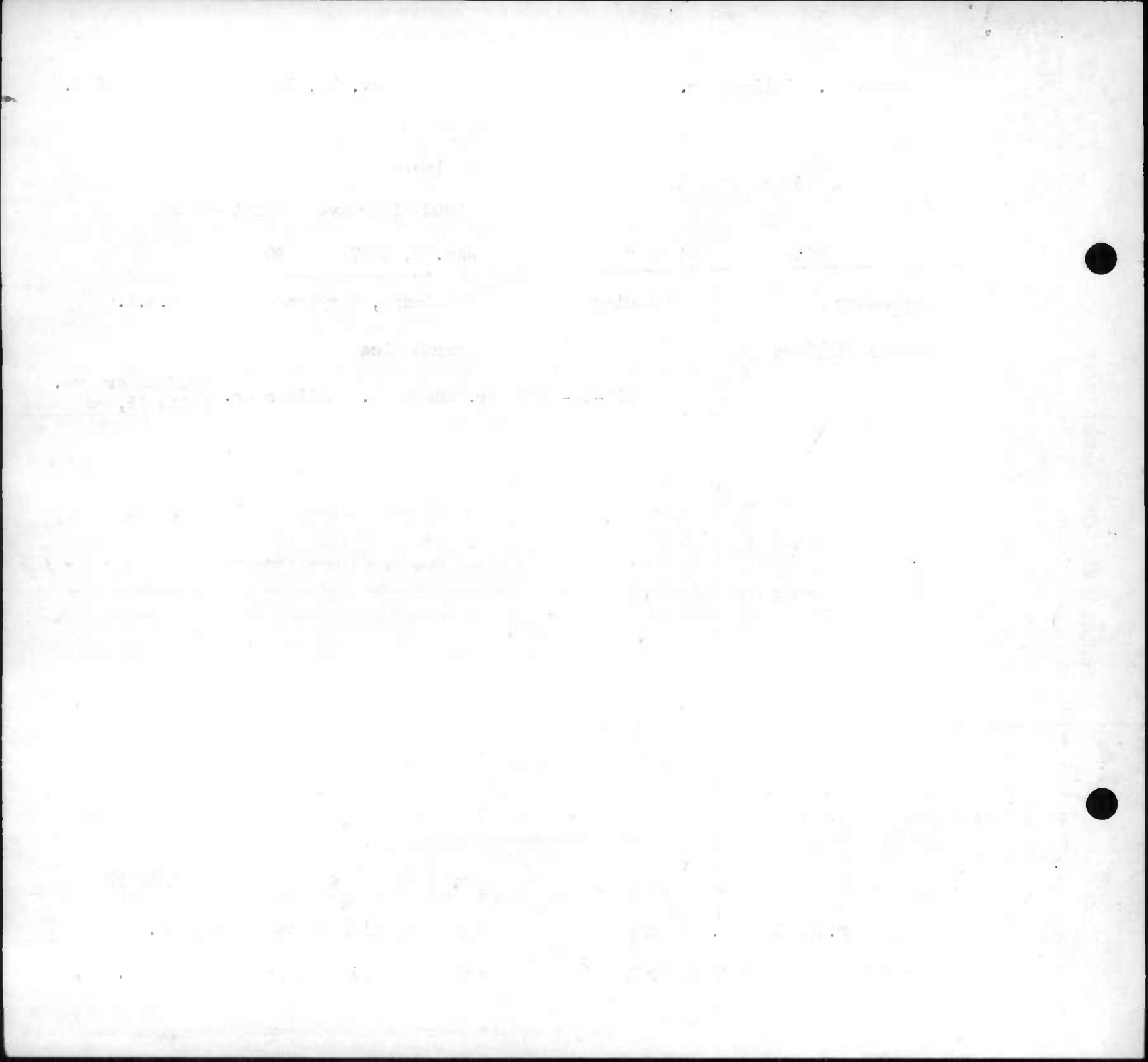
BIRTH NO. 67 11056		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 11056	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HOWARD W. TURNER, SR.		2. DATE AND HOUR OF DEATH November 14, 1967 2:20 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		5. SEX Male	
FULL NAME OF HOSPITAL OR INSTITUTION 00 619 S. Lehigh St. Baltimore, 21224, Md.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore # 21224, 26-07		6. RACE White	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH Feb, 27, 1906		9. AGE (In years last birthday) 61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Senior Foreman		10B. KIND OF BUSINESS OR INDUSTRY Schluderberg-Kurdle		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Albert Turner		14. MOTHER'S MAIDEN NAME Sarah Obitz	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-3466		17. INFORMANT Mildred M. Turner	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I CAUSE OF DEATH Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. DATE OF OPERATION 0	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		22. CONDITION FOR WHICH OPERATION WAS PERFORMED		23. AUTOPSY? (Yes or No)	
24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
27. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		28. HOW DID INJURY OCCUR?		29. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
30. I certify that (I) (this hospital) attended the deceased from 7-1-60 19 to 11-14-67 19, that (I) (we) last saw the deceased alive on 11-10-19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		31. SIGNATURE John Costantini		32. DATE SIGNED 11-15-67	
33. PHYSICIAN'S NAME (Type) John Costantini		34. ADDRESS 234 S. Conkling St. Balto., 21224, Md.		35. DATE 11-17-67	
36. BURIAL CREMATION, REMOVAL (Specify) Burial		37. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		38. LOCATION (City, town, or county) (State) 7225 Eastern Blvd., Ba. Co., Md.	
39. DATE REC'D BY HEALTH DEPT. NOV 20 1967		40. NAME OF REGISTRAR Robert E. Salyers		41. FUNERAL DIRECTOR Charles S. Zeiler	
42. ADDRESS 901 S. Conkling St. Balto., 21224, Md.					



FUNERAL DIRECTOR: IMPORTANT

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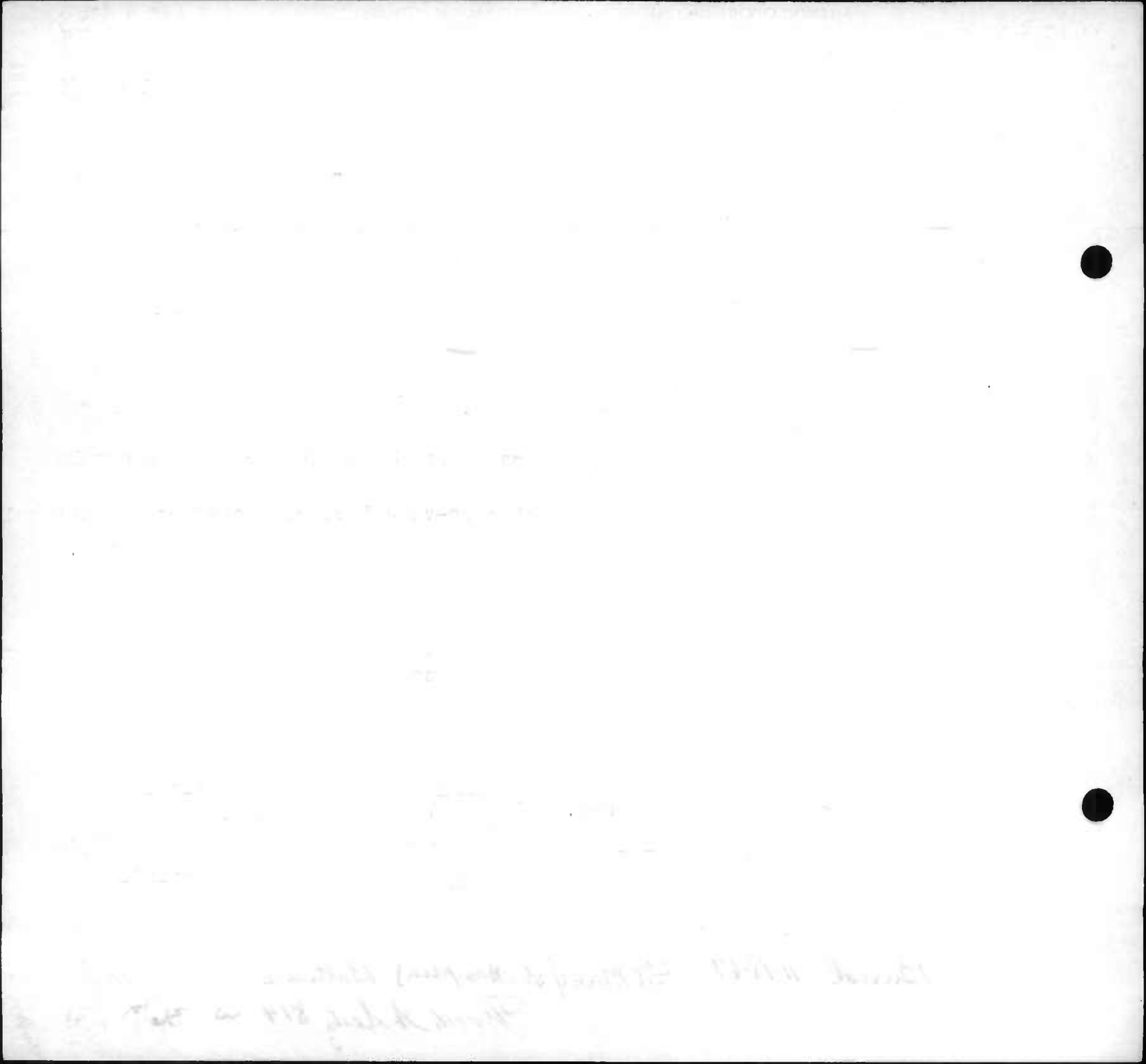
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11057</b>	
67 11057				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Edmund D. Williams Sr.</b>				<b>Nov. 14, 1967 8 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <b>4902 Elmer Avenue</b>		A. STATE <b>Maryland</b> B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>4902 Elmer Ave Baltimore 15</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 2, 1887</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Eugene Williams</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Rice</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-10-0303</b>		17. INFORMANT <b>Mr. Edmund D. Williams Jr. 4902 Elmer Ave. Balto 15, Md</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Emphysema</b> <b>Arteriosclerosis</b> <b>Pericarditis</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>June 1967</b> <b>June 1967</b> <b>June 1967</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>none</b>		20A. AUTOPSY? (Yes or No) <b>none</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <b>none</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>none</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>none</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>none</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> While Not At Work <input type="checkbox"/> <b>none</b>		21F. HOW DID INJURY OCCUR? <b>none</b>	
22. I certify that (I) (the hospital) attended the deceased from <b>June 27 1967</b> to <b>November 14 1967</b> , that (I) (we) last saw the deceased alive on <b>November 14 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Milton E. Lowman</b>				23B. DATE SIGNED <b>11/16/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Milton E. Lowman</b>				23D. ADDRESS <b>4843 Park Heights Ave Balto, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/17/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Pikesville Balto Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 20 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Loring Byers</b>	
				ADDRESS <b>8728 Liberty Rd Randalltown Md</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
67 11058		67 11058		67 11058	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Charles Ross Mc Cann		November 16, 1967 12:30 PM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
2413 Maryland Avenue Baltimore, Maryland		Maryland			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
Male		White		Widowed	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Carpenter		Construction		May 28, 1875	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
				92 yrs	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)	
No		218-18-3312		Maryland	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		218-18-3312		Mr. James Letzinger 801 W. 38th St. 21211	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		congestive heart failure six months	
ANTECEDENT CAUSES		(B) DUE TO		cerebro-vascular arteriosclerosis several yrs.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
D				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from APRIL 19 60 to 11-16-67 19 67, and that (I) (we) last saw the deceased alive on Nov. 14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
E. Ellsworth Cook M.D.				11-16-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
E. Ellsworth Cook				2431 Maryland Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		11-18-67		St Marys (Hamden)	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		11-18-67		St Marys (Hamden)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 20 1967		R. E. Fairbank		Frank H. Seitz 814 W. 36th St	



5-362

67 11059

BALTIMORE CITY HEALTH DEPARTMENT

67 11059

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MARGARETB. STRICKER

2. DATE AND HOUR PRONOUNCED DEAD

November 14, 1967 5:35 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3501 Hudson St. # 21224

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Oct. 25, 1901

9. AGE (In years  
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

House Work

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Sebastian Stricker

14. MOTHER'S MAIDEN NAME

Appolonia Neuslein

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

Mary C. Stricker

ADDRESS

Same.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Myocardial infarction  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 15, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11-18-67

23C. NAME of CEMETERY or CREMATORY

Sacred Heart Cemetery

23D. LOCATION

7401 German Hill Rd., Md.

24A. DATE REC'D BY HEALTH DEPT.

NOV 20 1967

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

Charles S. Geiler

901 S. Conkling St.  
Balto., 21224, Md.

1. The first part of the report is a general description of the project. This includes the objectives, the scope of the work, and the methods used. The second part is a detailed description of the results of the work. This includes a discussion of the data collected, the analysis of the data, and the conclusions drawn from the data. The third part is a summary of the work. This includes a brief overview of the project, the results, and the conclusions.

2. The first part of the report is a general description of the project. This includes the objectives, the scope of the work, and the methods used. The second part is a detailed description of the results of the work. This includes a discussion of the data collected, the analysis of the data, and the conclusions drawn from the data. The third part is a summary of the work. This includes a brief overview of the project, the results, and the conclusions.

3. The first part of the report is a general description of the project. This includes the objectives, the scope of the work, and the methods used. The second part is a detailed description of the results of the work. This includes a discussion of the data collected, the analysis of the data, and the conclusions drawn from the data. The third part is a summary of the work. This includes a brief overview of the project, the results, and the conclusions.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11060

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

67 11060

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Green - Robert Lee

2. DATE AND HOUR OF DEATH

11-18-67

3:25 a. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

91 KESWICK  
700 W. 40th ST - 21211

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Keswick

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore - Maryland

D. STREET ADDRESS (If rural, give location)

700 W. 40th Street - 21211

5. SEX

M

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Feb. 10 - 1891

9. AGE (In years last birthday)

75

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

?

11. BIRTHPLACE (State or foreign country)

Baltimore - Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Green - Robert Sinclair

14. MOTHER'S MAIDEN NAME

Flora Lee

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

064-05-9878A

17. INFORMANT

Rachel C. Gibson-P.R.

ADDRESS

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Chronic pyelonephritis  
DUE TO

(B) Fracture of rt. hip  
DUE TO

(C) Generalized atherosclerosis  
DUE TO

INTERVAL BETWEEN ONSET AND DEATH

6 mos

6 mos

5 yrs

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Laennec's Cirrhosis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 4 1967 to Nov. 18 1967, that (I) (we) last saw the deceased alive on 11-18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

E. Hunter Wilson, Jr.

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11-18-67

23C. PHYSICIAN'S NAME (Type)

E. Hunter Wilson, Jr. M.D.

M.D.

23D. ADDRESS

Medical Arts Building

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/20/67

24C. NAME of CEMETERY or CREMATORY

St. Mary's, Hampden

24D. LOCATION (City, town, or county) (State)

3900 Roland Ave, Balto, Md

25A. DATE REC'D BY HEALTH DEPT.

NOV 20 1967

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Austin E. Donovan - 3818 Roland Ave

1912-1913

the first of the  
Fascist (or  
German) movement

1913-1914

of the Fascist

1914-1915

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) Not a physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11061		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11061	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Lebbeus A. Stewart.</b>			2. DATE AND HOUR OF DEATH <b>Nov 16, 1967</b>   <b>5<sup>00</sup> P. M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>44 Union Memorial Hosp.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>13-07</b> <b>3838 Roland Ave</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>July 5, 1893</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Coffee Roaster</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			13. FATHER'S NAME <b>George F. Stewart.</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Clark</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>? ?</b>		
16. SOCIAL SECURITY NO. <b>?</b>			17. INFORMANT ADDRESS <b>Anne L. Stewart. 3838 Roland Ave</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>420.1 I</b> <b>Pulmonary Edema, acute</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <b>Congestive Heart Failure</b> <b>Multiple Myocardial Infarction</b>		
INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>12 yrs</b> <b>12 yrs</b>			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Pulmonary Embolism</b> <b>years</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 23, 1967</b> to <b>Nov. 16, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 11, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Albert B. Bradley</b>				23B. DATE SIGNED <b>11/18/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALBERT B. BRADLEY, M.D.</b>				23D. ADDRESS <b>4900 BELAIR RD. BALTO., MD. 21206</b>	
24A. CREMATION, REMOVAL (Specify)		24B. DATE <b>11/20/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Greenmount Crematory</b>	
24D. LOCATION (City, town, or county) (State) <b>Greenmount &amp; Oliver St., Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 20 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>Austin C. Donovan - 3818 Roland Ave</b>					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11062		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 11062	
1. NAME OF DECEASED (Type or Print) <b>Virginia Alice North</b>			2. DATE AND HOUR OF DEATH <b>November 16, 1967</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>90 Silver Cross Home 5124 Greenwich Avenue</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>5124 Greenwich Avenue</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>9-11-1874</b>	9. AGE (In years last birthday) <b>93</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Culver Simms, Jr.</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Mylius</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mr. Ernest C. North, 6145 Regent Park Rd. 21228</b>		
18. <b>45601</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Anteroinfarct vascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic brain syndrome</b>			INTERVAL BETWEEN ONSET AND DEATH <b>years</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. M. Theodore Boss</b> M.D.				23B. DATE SIGNED <b>17 Nov 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. M. Theodore Boss</b>				23D. ADDRESS M.D. <b>Medical Arts Bldg.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-18-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 20 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>			

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

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1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

FUNERAL DIRECTOR: IMPORTANT 1767

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		JOSEPH COHEN		67 11063		67 11063	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				JOSEPH COHEN		11/17/67 1:16 PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL 33				MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				6110 BELLINGHAM COURT			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY?
MALE	WHITE	MARRIED	11-01-06	61			USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
WASHINGTON Rep			LOBAYIST		MARYLAND		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
CHARLES COHEN				TILLIE KLEINMAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		216-12-6184		Wife		Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) GI bleeding			
ANTECEDENT CAUSES				(B) Metastatic Ca of carcinoma			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
				Jun, 1966			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
D				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/1/67 19 to 11/17/67 19, that (I) (we) last saw the deceased alive on 11/17/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Allen B. Kaiser, M.D.				11/17/67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
ALLEN B. KAISER				JHH JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		11/19/67		Chubb Amundson		Balto Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 20 1967		Robert E. Farkas		SYLVAN LEWIS & SON GARRISON, Md			



14/10/07

100-21-1

மேலும் சில செய்திகள்

239. mT

4475

11/12/07

4/1/07

5/17/10

E-1521

67 11064

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 67 11064

BIRTH NO. <u>1</u>		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <u>EVANS, LESLIE ROBERT</u>		2. DATE AND HOUR OF DEATH <u>Nov. 15, 1967 10:45 AM</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>The James Lawrence Kernan Hospital</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE CO.</u>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
		D. STREET ADDRESS (If rural, give location) <u>3503 St. James Road</u>	
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 5, 1904</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Technical Writer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Electronics</u>	9. AGE (In years last birthday) <u>63</u>
13. FATHER'S NAME <u>Robert Allison</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
16. SOCIAL SECURITY NO. <u>360-22-0836</u>		17. INFORMANT <u>Katherine Evans-3503 St. James Road</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Brain Tumor</u>		19. AGE (In years last birthday) <u>63</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. DATE OF BIRTH <u>March 5, 1904</u>	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		22. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
23. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <u>None</u>		20A. AUTOPSY? (Yes or No)	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 4, 1967</u> to <u>Nov. 15, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov. 15, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		21F. HOW DID INJURY OCCUR?	
23A. SIGNATURE <u>Albert Folgueras</u>		23B. DATE SIGNED <u>11-15-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALBERT FOLGUERAS</u>		23D. ADDRESS <u>Kernan Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-18-67</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Mausoleum</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE RECEIVED BY HEALTH DEPT. <u>NOV 20 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Ellsworth Armacost-4600 Liberty Hghts. Ave</u>		25D. ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



C-552

67 11065

BALTIMORE CITY HEALTH DEPARTMENT

67 11065

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HELEN CUMMINGS

2. DATE AND HOUR PRONOUNCED DEAD

November 15, 1967

3:25 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

336 Folcroft Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

July 19, 1907

9. AGE (In years  
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Calvin Henry

14. MOTHER'S MAIDEN NAME

Margaret Kane

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Robert Cummings, 95 Indian Rock Dam Rd.  
York, Pa.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TOANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
m. WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

November 16, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

burial

23B. DATE

11-18-67

23C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore County, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 20 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

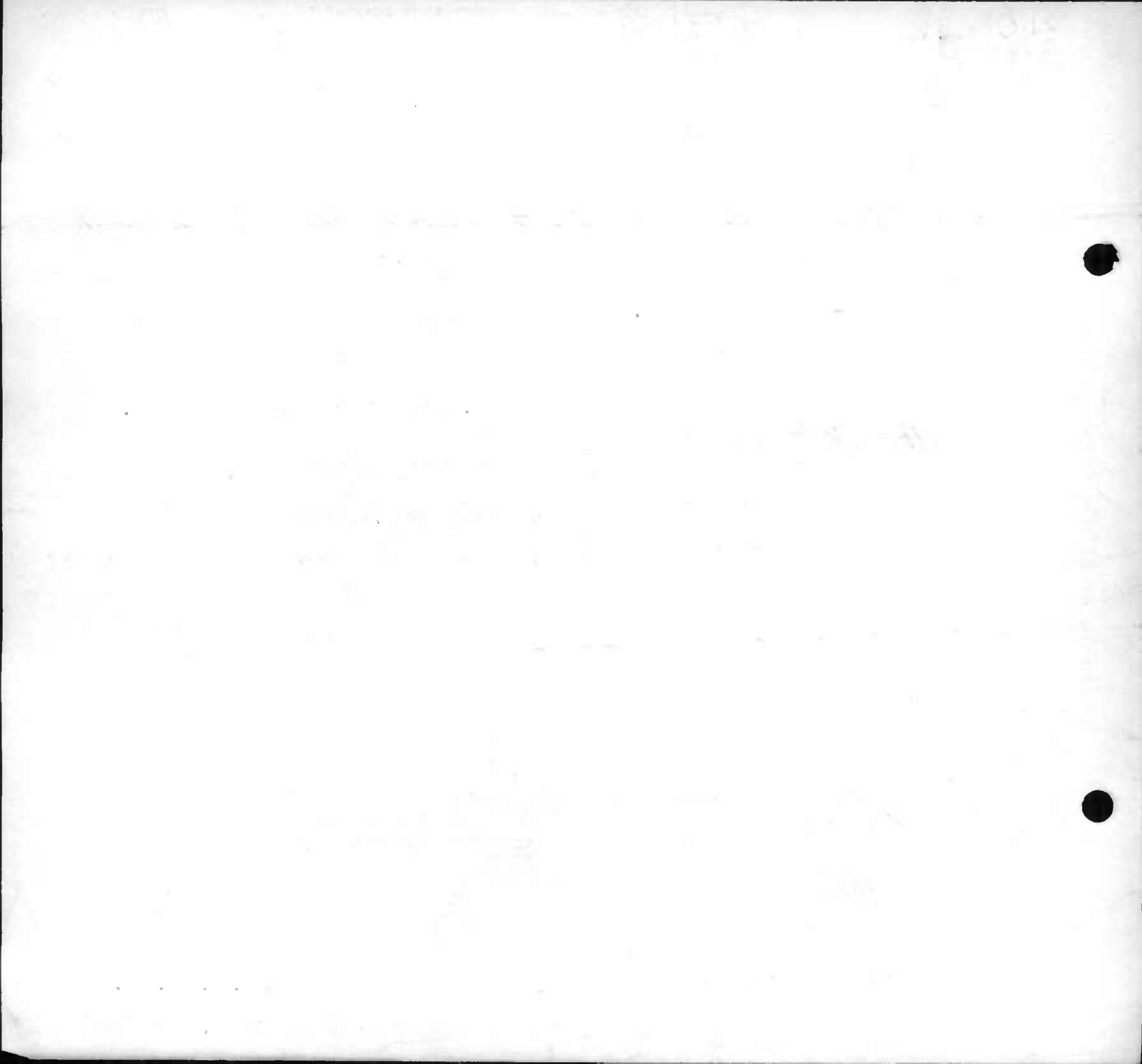
Ullrich Funeral Home, Dundalk, Md.

WILLIE PUGH  
MILBURY WOODS  
250 BROAD STREET



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 11066		67 11066		67 11066	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Ella May Bishop		Nov 18, 1967		18:27 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md		B. COUNTY Baltimore Co	
UNION Memorial Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
44		D. STREET ADDRESS (If rural, give location)		53-00	
2309 Ellen Ave					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days
F	W	Married	08/27/64	63	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Saleslady-Retired		Dept. Store		Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U S A		David Kern		Mary Hughes	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				Mr. Ralph Bishop	
				2008 Harman Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Ventricular Asystole		5 min.	
ANTECEDENT CAUSES		(B) Recurrent Ventricular fibrillation		3 hrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Arteriosclerotic Heart Disease		3 months	
II		Diabetes Mellitus		4 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Sept 15 1967 to Sept 18 1967, that (we) last saw the deceased alive on Sept 18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Alan B. Cohen				11/18/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		3501 St Paul St. Balto Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11 22 67		Cedar Hill	
24D. LOCATION (City, town, or county)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
Brooklyn, A. A. Co. Md.		Mc Gully		130 E. Fort Ave	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 20 1967		R. E. Farley, MD		Mc Gully	
VS 150-REV. 11/765					



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 11067

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ESTHER R. CLISSO

2. DATE AND HOUR PRONOUNCED DEAD

November 17, 1967

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Essex (21)

D. STREET ADDRESS (If rural, give location)

924 Foxwood Lane

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Sept. 18, 1937

9. AGE (In years  
last birthday)

30

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Nurse

10B. KIND OF BUSINESS OR INDUSTRY

Hospital

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

William Morgan

14. MOTHER'S MAIDEN NAME

Belle Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown. If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

164 32 0181

17. INFORMANT

Llewelyn Clisso

ADDRESS

Same

18. E 970.81

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Suppurative Pyelonephritis  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Ingestion of overdose of doriden

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

924 Foxwood Lane

21D. TIME  
OF INJURY  
(APPROX.)

UNK

(Month) (Day) (Year) (Hour)

UNK

21E. INJURY OCCURRED

m.

WHILE AT

WORK

NOT WHILE

AT WORK

21F. HOW DID INJURY OCCUR?

ingested overdose of sleeping pills

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

11/18/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/20/67

23C. NAME OF CEMETERY or CREMATORY

Holly Hill Memorial Gardens Baltimore Co., Md.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 20 1967

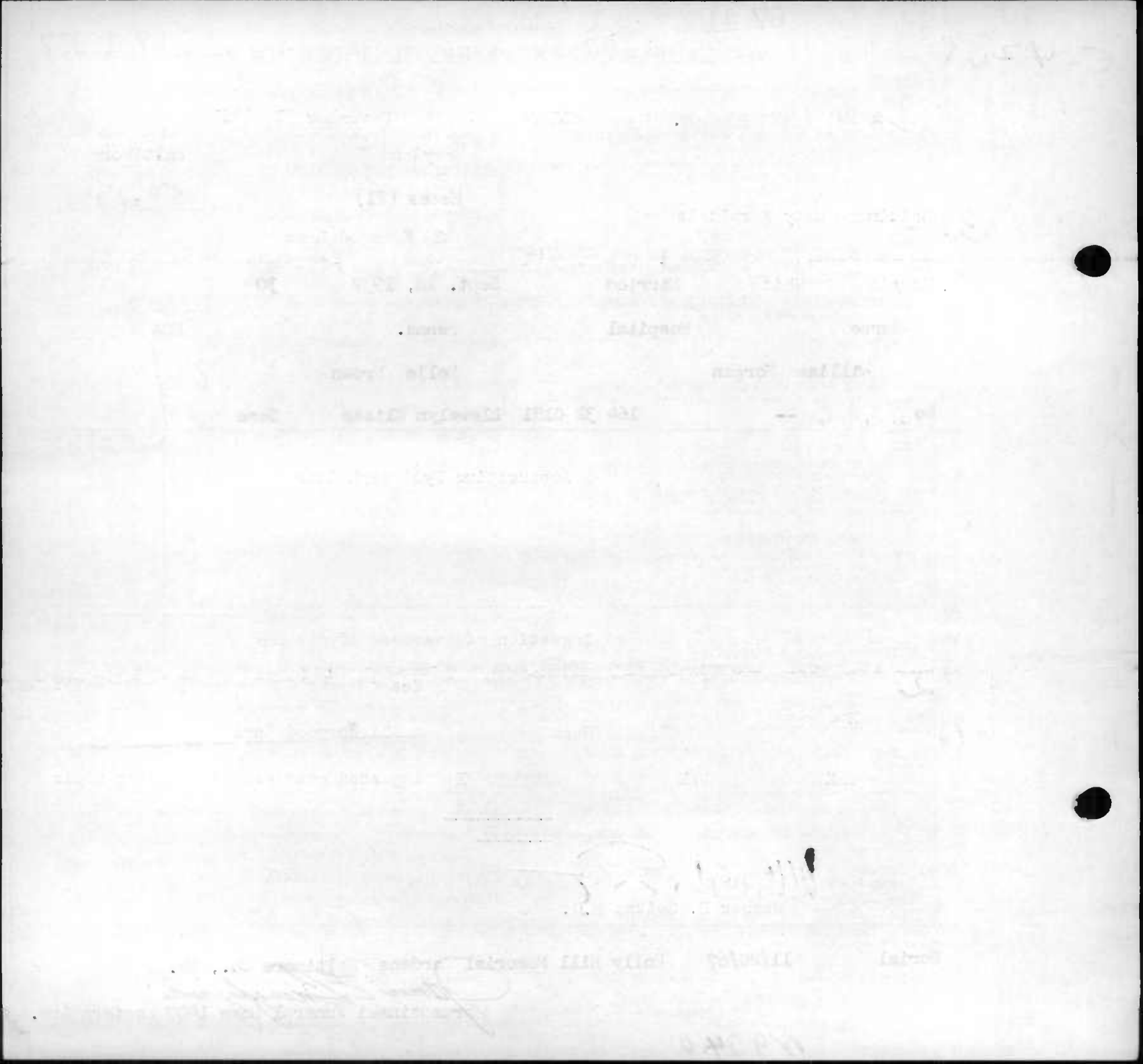
24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

Bruzdzinski Funeral Home 1407 Eastern Ave.

ADDRESS



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11068

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CHRISTOPHER MACK

2. DATE AND HOUR PRONOUNCED DEAD

November 12, 1967 9:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

909 South Bouldin Street # 21224 ,

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

December 10, 1899 67

9. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Stand. Oil Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Adam Mack

14. MOTHER'S MAIDEN NAME

Louise Schreiber

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

214-01-4378

17. INFORMANT

ADDRESS

Mildred T. Mack : 909 S. Bouldin St. # 24

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH420.0 I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic heart disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 13, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11-16-67

23C. NAME of CEMETERY or CREMATORY

Sacred Heart Cem.

23D. LOCATION

(City, town, or county) (State)

7401 German Hill Rd. Ba. Co., Md

24A. DATE REC'D BY HEALTH DEPT.

NOV 20 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Charles S. Springate

901 S. Conkling St.  
Balto., 21224, Md.

WALTER P. MOORE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>67 11069</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>67 11069</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>METZGER MRS. SOPHIE, M.</b>			2. DATE AND HOUR OF DEATH <b>11-12-1967 7:35 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>CHURCH HOME AND HOSPITAL 35 BALTIMORE</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE ESSEX 53-00</b> D. STREET ADDRESS (If rural, give location) <b>Apt 67 B FENWAY, NORTH #21221</b>		
5. SEX <b>Female</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>1-28-1903</b>	9. AGE (In years lost birthday) <b>64</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND, BALTIMORE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>FREDERICK BERENDS (Frederick L. Berends)</b>			14. MOTHER'S MAIDEN NAME <b>MEYER Louise Myers</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218 22 - 0323</b>		17. INFORMANT <b>John Metzger</b>	
				ADDRESS <b>Same</b>	
18. <b>422.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Ante-mortem Cardio Vascular Disease.</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
INTERVAL BETWEEN ONSET AND DEATH <b>4 Months.</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Thyroidosis Rheumatoid Arthritis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 Months. Years</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>  N  </u> (this hospital) attended the deceased from <u>  10-31  </u> 19 <u>  67  </u> to <u>  11-12  </u> 19 <u>  67  </u> , that <u>  N  </u> (we) last saw the deceased alive on <u>  11-12  </u> 19 <u>  67  </u> and that in <u>  my  </u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>  N  </u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jose Martinez</i>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11/12/67</b>
23C. PHYSICIAN'S NAME (Type) <b>Jose MARTINEZ</b>			23D. ADDRESS M.D. <b>Medical Out Bldg 2120 N.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-16-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>	
				24D. LOCATION (City, town, or county) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 20 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Charles S. Jailer</b>	
				901 S. Conkling St. Balto., 21224, Md.	

11-12-1967

BALTIMORE  
CHURCH HOME AND HOSPITAL  
Baltimore  
478 PENWAY  
Baltimore

Chesapeake Center  
Chesapeake Division

Reynolds Bank  
Baltimore

for Mary  
JOE MARTINEZ

Medical Care Fund

11 - 12 - 67

11/12/67  
5100 P.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11070		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11070	
BIRTH NO.		M.E. CASE NO.		E	
1. NAME OF DECEASED (Type or Print)		Viola SHAFFER		2. DATE AND HOUR OF DEATH 11-16-67 5:25 PM M.	
<div style="font-size: 2em; font-weight: bold;">CERTIFICATE AMENDED</div>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND BALTIMORE COUNTY	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
5. SEX F				6. RACE W	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE				8. DATE OF BIRTH 12-21-85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10B. KIND OF BUSINESS OR INDUSTRY Housekeeper	
13. FATHER'S NAME JOHN H. Shaffer				14. MOTHER'S MAIDEN NAME ANNIE D. STANSBURY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-18-7316	
17. INFORMANT William B. Stansbury Jr.				ADDRESS 403-05 21202	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Tracheobronchial hemorrhage 10 min DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coagulation deficiency 10 hrs DUE TO Gram-negative sepsis 24 hrs DUE TO				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 1:30 AM 11/16 19 67 to 5:25 PM 11/16 19 67, that (we) last saw the deceased alive on 11-16-67 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE John V. Russo				23B. DATE SIGNED 11-16-67	
23C. PHYSICIAN'S NAME (Type) John V. Russo				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-20-67		24C. NAME OF CEMETERY or CREMATORY Hiss Methodist Cemetery	
24D. LOCATION Baltimore Co.		24E. ADDRESS Md.		24F. ADDRESS 36	
25A. DATE REC'D BY HEALTH DEPT. NOV 20 1967		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Loseval Funeral Home 7401 B. Ave. East	

12/4/69. Caretaker farm from General Director.  
JSC.

D-500

67 11071 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

67 11071

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HARVEY Z. DONEHOO

2. DATE AND HOUR PRONOUNCED DEAD

November 14, 1967

6:50 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)40  
99 St. Agnes Hospital D.O.A.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5710 Oakland Rd.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Married

8. DATE OF BIRTH

May 15, 1919

9. AGE (In years  
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Tavern Owner

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Atlanta, Georgia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Arthur

O.

Donehoo

14. MOTHER'S MAIDEN NAME

Estelle

Jenkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War II

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. K. L. Burucker 3435 Gaither Road

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH422.1 I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic Cardiovascular

Disease

(B) DUE TO

(C) DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
m. WORKNOT WHILE  
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/17/67

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cemetery

23D. LOCATION

November 15, 1967

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

NOV 20 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Wm. J. Jackson &amp; Sons Baltimore, Md.

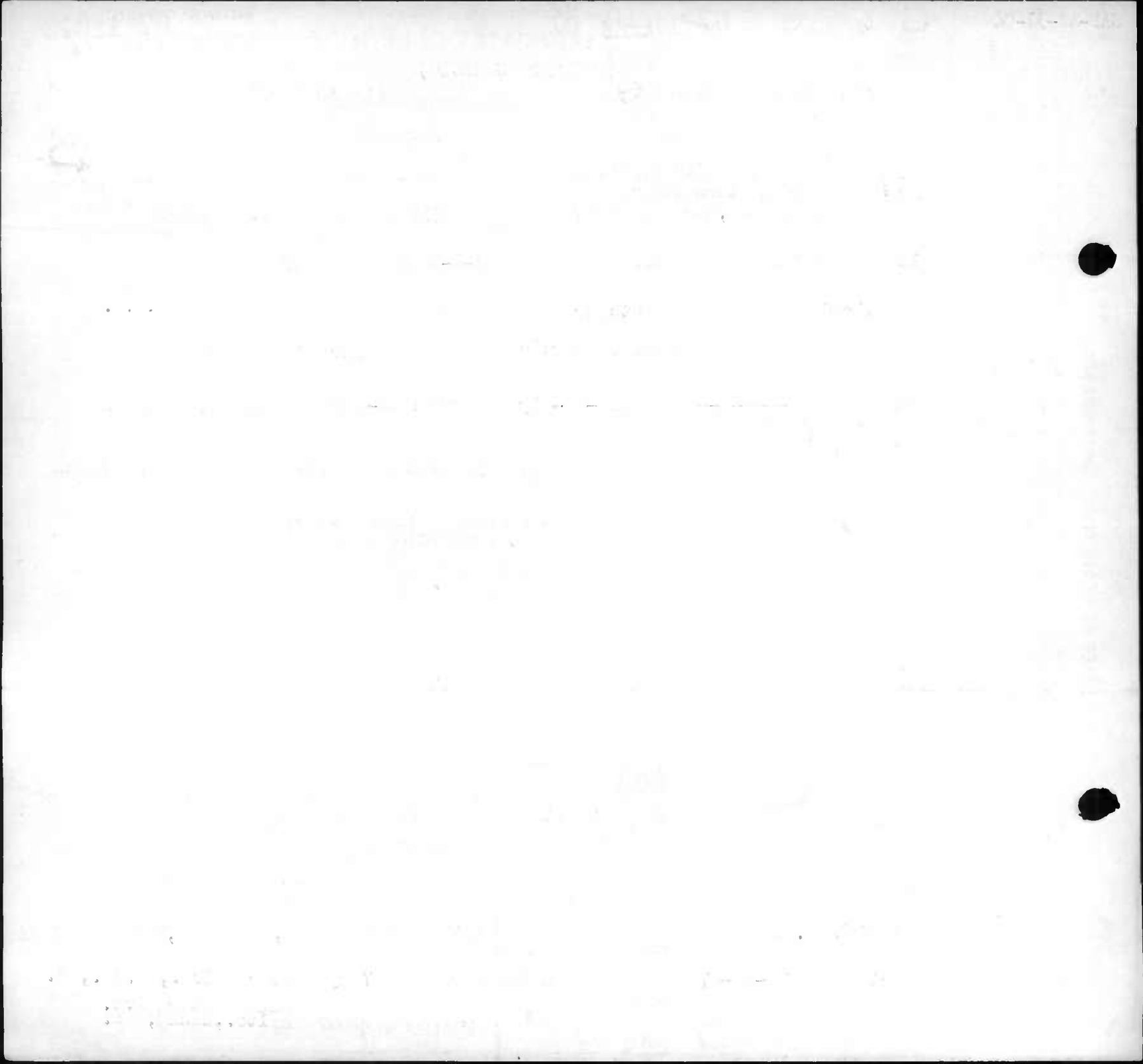
ADDRESS

80

OFFICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

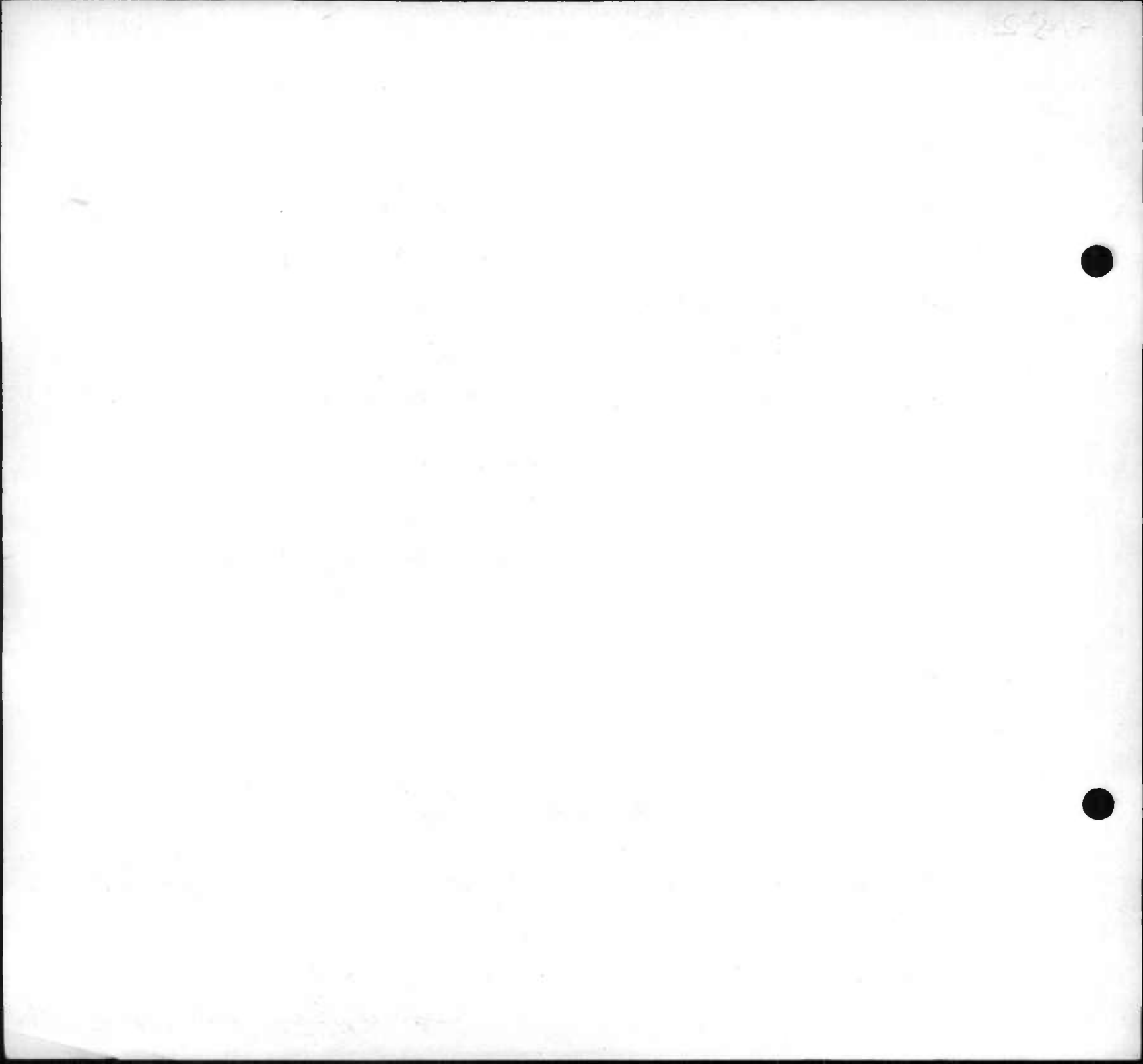
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 11072	
BIRTH NO. 67 11072					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>ANTHONY GUERCIO</b>			2. DATE AND HOUR OF DEATH <b>11-15-67 11 50 A M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>			A. STATE <b>Maryland</b> B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>4917 Eastern Avenue 21224</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>4-2-1892</b>	9. AGE (In years last birthday) <b>75</b>	10. Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Butcher</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Vincent Guercio</b>		
14. MOTHER'S MAIDEN NAME <b>Nicasia ?</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>220-18-8196A</b>			17. INFORMANT ADDRESS <b>Records: BCH-4940 Eastern Avenue 21224</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCTION</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>RECTAL BLEEDING - SIVERTICULITIS -</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-6-1967</b> to <b>11-15-1967</b> , that (I) (we) last saw the deceased alive on <b>11-15-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Daniel D. Foote</b>				23B. DATE SIGNED <b>11-15-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Daniel D. Foote</b>				23D. ADDRESS <b>4940 Eastern Avenue, Baltimore, Maryland 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-18-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>7225 Eastern Blvd., Ba. Co., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 20 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Charles S. Geller</b>		25D. ADDRESS <b>6224 Eastern Ave. Balto., 21224, Md.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11073		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11073	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
WILLIAM JOHN SPENCER		11-16-67			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
827 N. BRADFORD ST. 00		MARYLAND			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE			
		D. STREET ADDRESS (If rural, give location)			
		827 N. BRADFORD ST.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. Under 1 Yr. Months Days Hours Min.
M	W	MARRIED	8-19-1911	56	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
STOREKEEPER		CITY		NEW YORK	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JOHN SPENCER		EMMA POESCH		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		112-10-2929		Mrs. Gabel V. Spencer - 827 N. Bradford St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
		Coronary occlusion			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Emphysema			
		(C) DUE TO			
		Respiratory infection			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1964 to Nov 14, 1967, that (I) (we) last saw the deceased alive on Nov 14, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Charles MacMinn				11/20/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		11-20-67		CEDAR HILL Cem.	
				24D. LOCATION (City, town, or county) (State)	
				BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 20 1967		Robert E. Johnson		Hartley Miller - 2334 Jefferson St.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

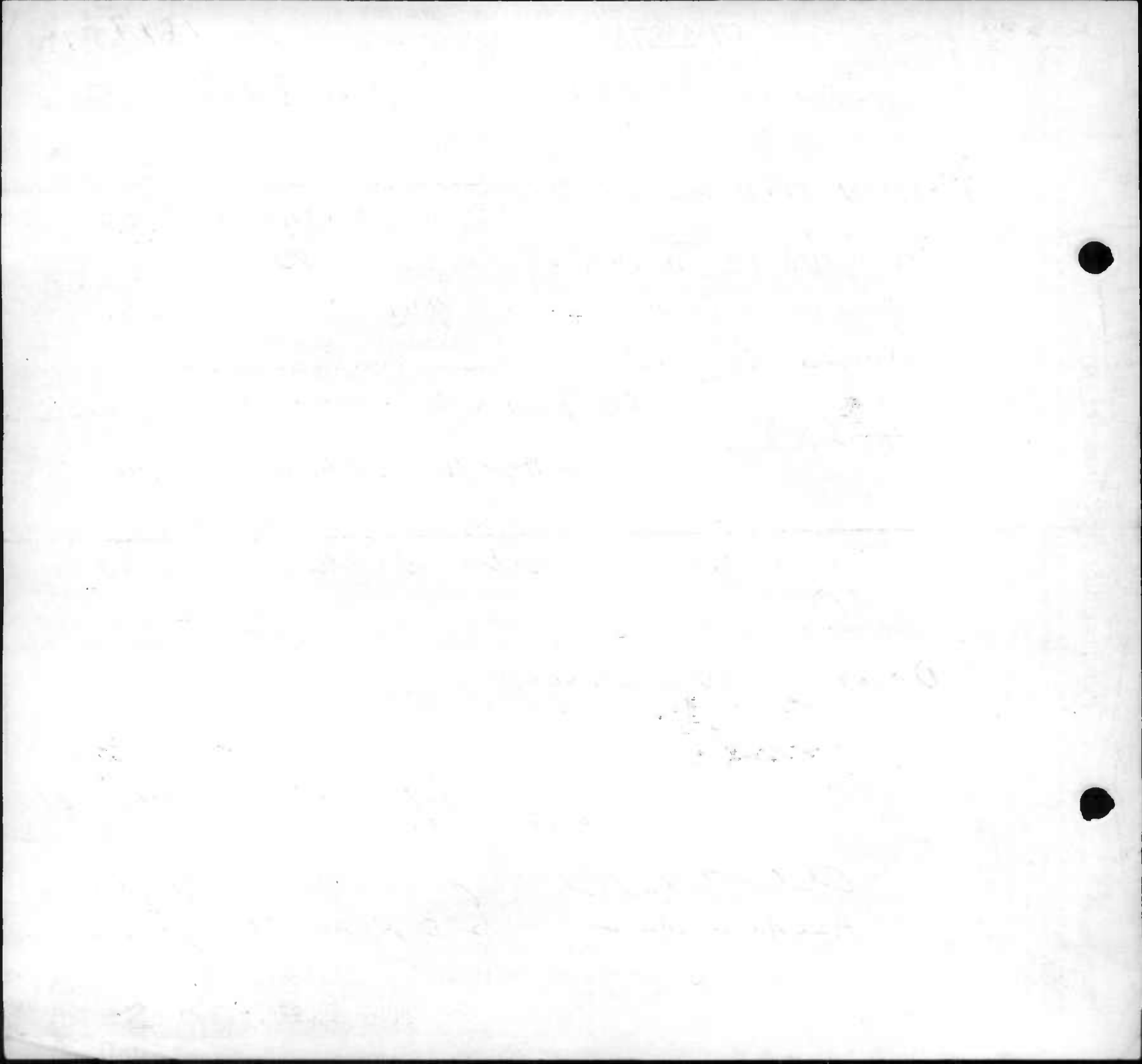
R-500

## BALTIMORE CITY HEALTH DEPARTMENT

67 11074 CERTIFICATE OF DEATH

Registered No. 104911074

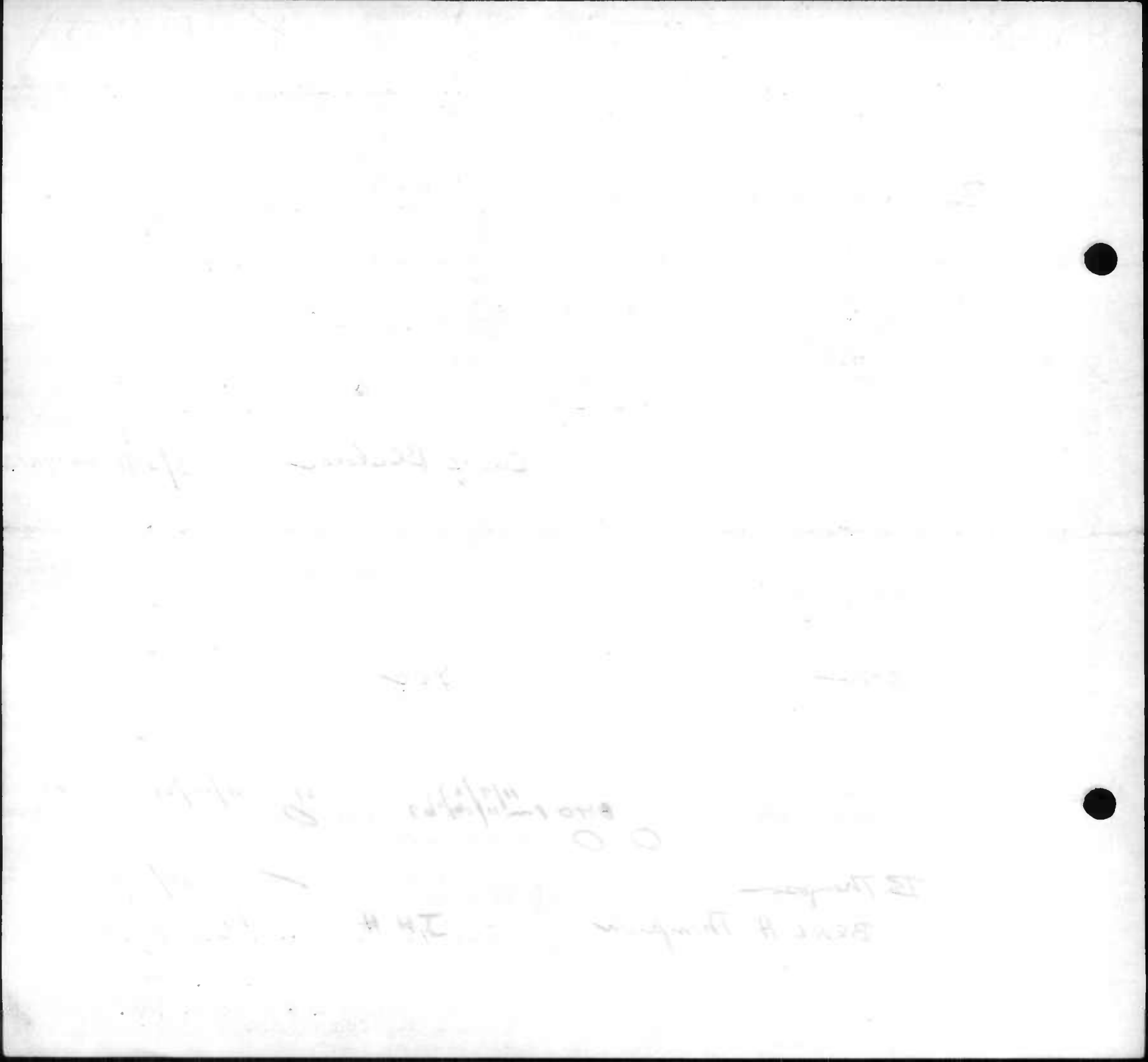
BIRTH NO. 67 11074		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) William James Rowan		2. DATE AND HOUR OF DEATH 11/17/67 @ 7:45 AM A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Bolton Hill Nursing Center		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-03 D. STREET ADDRESS (If rural, give location) 3950 Southclaire Rd	
5. SEX m	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 10/21/87
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouse Man (ret)		10B. KIND OF BUSINESS OR INDUSTRY Seaboard Brass & Copper Co.	9. AGE (In years last birthday) 80
11. BIRTHPLACE (State or foreign country) md		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Rowan		14. MOTHER'S MAIDEN NAME Elizabeth Arnold	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213 108141	
17. INFORMANT Allan V. Rowan, son, 5611 Knell Ave.,		ADDRESS 21206	
18. 443 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Hypertension C.V. disease (B) arteriosclerosis (C) aortic aneurysm INTERVAL BETWEEN ONSET AND DEATH yes years 10/67			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 10/10/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED aortic aneurysm	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/11/1967 to 11/17/1967, that (I) (we) last saw the deceased alive on 11/17/1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Allan H. Macht M.D.		23B. DATE SIGNED 11/17/67	
23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHT M.D.		23D. ADDRESS 2 E. READ ST 21206	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/20/67	
24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 20 1967		25B. NAME OF REGISTRAR Robert E. Fairbank	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11075</b>
BIRTH NO. <b>67 11075</b>		<b>CERTIFICATE OF DEATH</b>		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>(OR HILDAGARDE MAAS)</b>		2. DATE AND HOUR OF DEATH <b>11-16-67 8:10 P. M.</b>
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balt Co</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1601 ROSEWICK AVE</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>12-25-97</b>	9. AGE (In years last birthday) <b>69</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>HERMAN BRUNS</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH STALLNECHT</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-03-9587D</b>	17. INFORMANT <b>577X Lucia Ave., 21229</b> <b>Roland Hierstetter, son,</b>	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Ca of Bladder</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>6/23/67 - 11/16/67</b>
18. <b>II</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>11/9/67</b> 19 <b>67</b> to <b>11/16/67</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8:10 PM 11/16/67</b> and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(I) (We) (did)</b> (did not) view the body after death.				
23A. SIGNATURE <b>B. Thompson</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/16/67</b>
23C. PHYSICIAN'S NAME (Type) <b>BRUCE H. Thompson</b>		23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>11/20/67</b>	24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 20 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> <b>3331 Brehms Lane</b>



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11076

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM O. HARRIS SR.

2. DATE AND HOUR PRONOUNCED DEAD

November 16, 1967 3:40 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 2110 Bolton St. D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2110 Bolton St.

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

3-28-1891

9. AGE (In years  
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR INDUSTRY

Self-employed

11. BIRTHPLACE (State or foreign country)

Cambridge, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Harris

14. MOTHER'S MAIDEN NAME

Helen Clash

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Miss Helen Harris 2110 Bolton St. 21217

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular  
DUE TO DiseaseANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 17, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11-20-67

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cemetery

23D. LOCATION

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

NOV 20 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Marshall W. Jones, Jr.

1735 Harford Avenue ADDRESS 21213

Palmer  
William Smith  
C. J. Smith  
C. J. Smith  
C. J. Smith  
C. J. Smith

Miss Helen Smith 1110 Belmont St. 1917

Miss Helen Smith 1110 Belmont St. 1917

11-10-17  
The Robert Company  
1110 Belmont Avenue 1917  
Miss Helen Smith

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11077		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11077	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		MILDRED A. PORTER		2. DATE AND HOUR OF DEATH NOV. 15, 1967 (Wed) 11 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		MARYLAND 28-04	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE 21229	
D. STREET ADDRESS (If rural, give location)		4423 MANORVIEW RD.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH JUNE 20, 1900	9. AGE (In years last birthday) 67	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOK FOLDER
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY BOOK BINDERS	11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME IRA J. PORTER, SR.		14. MOTHER'S MAIDEN NAME LILLIE V. FOSTER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-07-3416		17. INFORMANT HILDA E. PORTER	
				ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtemia, etc. It means the disease, injury or complication which caused death.) 170X I CARCINOMA R. BREAST & GENL. METASTASES		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 8 MO.	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-30 19 67 to 11-15 19 67, that (I) (we) last saw the deceased alive on 11-13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John F. Schaefer		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED NOV. 17 1967	
23C. PHYSICIAN'S NAME (Type) JOHN F. SCHAEFER		23D. ADDRESS 401 RANDOM RD. - BALTO. MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE SAT. 11-18-67		24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK	
				24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. NOV 20 1967		25B. NAME OF REGISTRAR P. E. E. Evans		25C. FUNERAL DIRECTOR CURTIS F. EVANS	
				ADDRESS 1400 S. CHARLES ST.	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-452		67 11078		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11078	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED <i>Mary Alice Williams</i>				11/16/67 11:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224				A. STATE Maryland B. COUNTY Anne Arundel County			
5. SEX Female				6. RACE Negro			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married				8. DATE OF BIRTH 3/30/14			
9. AGE (In years last birthday) 53				10. CITIZEN OF WHAT COUNTRY? U.S.A.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY			
11. FATHER'S NAME James Galloway				12. MOTHER'S MAIDEN NAME ?? Rosie Brown			
13. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				14. SOCIAL SECURITY NO.			
15. INFORMATION				ADDRESS #21224 BCH: Records 4940 Eastern Ave. Baltimore, Md.			
16. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
17. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Septicemia from decubitus Ant. Spinal Artery thrombosis Syphilis				Oct 67 5 yrs. ?			
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
20. MEDICAL CERTIFICATION							
21. DATE OF OPERATION None				22. CONDITION FOR WHICH OPERATION WAS PERFORMED			
23. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
25. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				26. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
28. HOW DID INJURY OCCUR?							
29. I certify that (I) (this hospital) attended the deceased from 7/14/67 to 11/16/67, that (I) (we) last saw the deceased alive on 11/16/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
30. SIGNATURE Michael Jaffe				31. DATE SIGNED 11/16/67			
32. PHYSICIAN'S NAME (Type) Michael Jaffe				33. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224			
34. BURIAL CREMATION, REMOVAL (Specify) Burial 11/20/67				35. NAME OF CEMETERY or CREMATORY Chew Memorial			
36. DATE REC'D BY HEALTH DEPT. NOV 20 1967				37. NAME OF REGISTRAR Robert E. Taylor			
38. FUNERAL DIRECTOR William Reese				39. ADDRESS Annapolis Md.			

18/10/19

18/10/19

18/10/19

18/10/19

18/10/19

18/10/19

P-640

67 11079 BALTIMORE CITY HEALTH DEPARTMENT

67 11079

BIRTH NO.

M.E. CASE NO.

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED  
(Type or Print)

DANIEL L. PRIOLEAU

2. DATE AND HOUR PRONOUNCED DEAD

November 13, 1967 9:05 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

608 S. Hanover Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

608 S. Hanover St.

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9/8/1914

9. AGE (In years  
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

S.E.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Frank Kinsman

14. MOTHER'S MAIDEN NAME

Queenie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mildred Sals 608 Hanover St.

18. 420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic heart disease  
DUE TO

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Chronic pulmonary emphysema

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

ASSISTANT MEDICAL EXAMINER ☒

November 14, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

NOV 20 1967

Robert E. Taylor, M.D.

W. Brown

108

11/10/11  
J. V. V.  
P. V.

11/10/11

11/10/11

11/10/11

67 11080

BALTIMORE CITY HEALTH DEPARTMENT

67 11080

BIRTH NO. 67-2 1907 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

(SHERRIE) SHERRY (RENEE) HAMLIN

2. DATE AND HOUR PRONOUNCED DEAD

November 12, 1967

10:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Sinai Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2401 Oswego Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

OCT 19, 1967

9. AGE (In years  
last birthday)

(3 weeks)

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

WILLIAM CARL L. HAMLIN

14. MOTHER'S MAIDEN NAME

LINDA FIELDER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

WILLIAM CARL L. HAMLIN

2401  
OSWEGO AVE

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Interstitial pneumonitis (SDII)  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 13, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

11-15-67

23C. NAME OF CEMETERY or CREMATORY

MOUNT AUBURN

23D. LOCATION (City, town, or county) (State)

BALTO Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

NOV 20 1967

Robert E. Jackson, M.D.

I. L. BROWN + SON

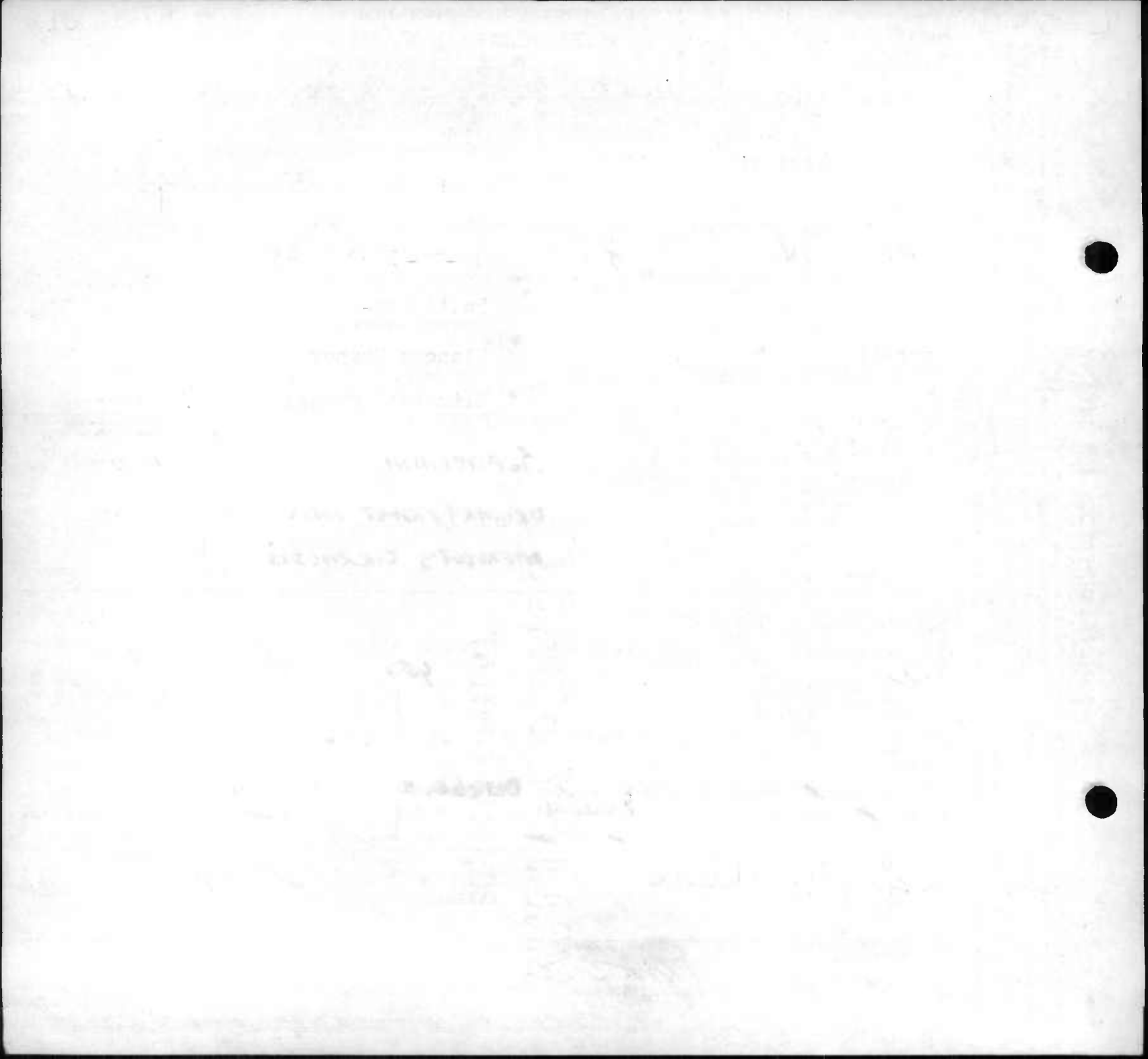
123 W. MONTGOMERY ST.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11081		BALTIMORE CITY HEALTH DEPARTMENT		67 11081	
BIRTH NO.		M.E. CASE NO.		Registered No.	
1. NAME OF DECEASED (Type or Print) <b>CARROLL CHANEY</b>			2. DATE AND HOUR OF DEATH <b>NOVEMBER 11, 1967 5<sup>20</sup> P</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Unveristity Hospital</b>			A. STATE <b>Md</b>		
B. COUNTY			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore City</b>		
D. STREET ADDRESS (If rural, give location) <b>784 W. Mulberry St</b>			E. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>17-03</b>		
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>3</b>	8. DATE OF BIRTH <b>II-20-1922</b>	9. AGE (In years last birthday) <b>45</b>	10. CITIZEN OF WHAT COUNTRY If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>L</b>			11. BIRTHPLACE (State or foreign country) <b>Baltimore-Md</b>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY		
13. FATHER'S NAME <b>Carroll .?</b>			14. MOTHER'S MAIDEN NAME <b>Blanche Chaney</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Elizabeth Chaney</b>			ADDRESS <b>784 W. Mulberry</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>SEPTICEMIA</b>			INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>URINARY TRACT INFECTION</b>			INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>LAENNEC'S CIRRHOSIS</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(I)</del> (this hospital) attended the deceased from <b>October 20, 1967</b> to <b>November 11, 1967</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>November 11, 1967</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>Gary L. Wilmer</b>				23B. DATE SIGNED <b>November 11, 1967</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/17/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn</b>	
24D. LOCATION (City, town, or county) (State) <b>Balt City</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 20 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>	
25C. FUNERAL DIRECTOR <b>W. Brown</b>		ADDRESS <b>10870 Mainway, N</b>			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">67 11082</span>	
BIRTH NO. <span style="font-size: 1.5em;">67 11082</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>MRS. VERONICA Wilson</i>		2. DATE AND HOUR OF DEATH <i>11/18/67</i> <span style="float: right;"><i>5:15 P.M.</i></span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>BON SECOURS</i> <i>34</i>		A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>20-07</i> D. STREET ADDRESS (If rural, give location) <i>52 S. Culver St</i>			
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>2/24/08</i>	9. AGE (In years last birthday) <i>59</i>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Woodstock, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>GABRIEL BENNETT</i>		14. MOTHER'S MAIDEN NAME <i>Emma</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-22-2033</i>		17. INFORMANT <i>Herbert S. Wilson, Sr. - 52 S. Culver St.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>443 XI H.A.S.C.V.D. - failure</i>		CAUSE OF DEATH (A) DUE TO <i>H.C.V.D.</i> (B) DUE TO <i>Generalized Arteriosclerosis</i> (C) <i>Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>days.</i> <i>years.</i> <i>years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Nov 8 1967</i> to <i>Nov. 18 1967</i> . that (I) (we) last saw the deceased alive on <i>Nov. 18 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Agustin del Campo.</i>				23B. DATE SIGNED <i>Nov. 18. 1967</i>	
23C. PHYSICIAN'S NAME (Type) <i>AGUSTIN del CAMPO.</i>				23D. ADDRESS <i>Bon Secours Hosp. Balto. Md</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-21-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Woodstock Catholic</i>	
24D. LOCATION (City, town, or county) (State) <i>Woodstock, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 20 1967</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Charles R. Law 802 Madison Ave.</i>			

222 6444

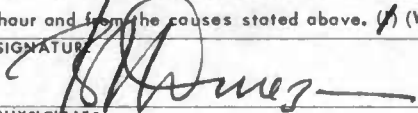
222 6444

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FUNERAL DIRECTOR: IMPORTANT

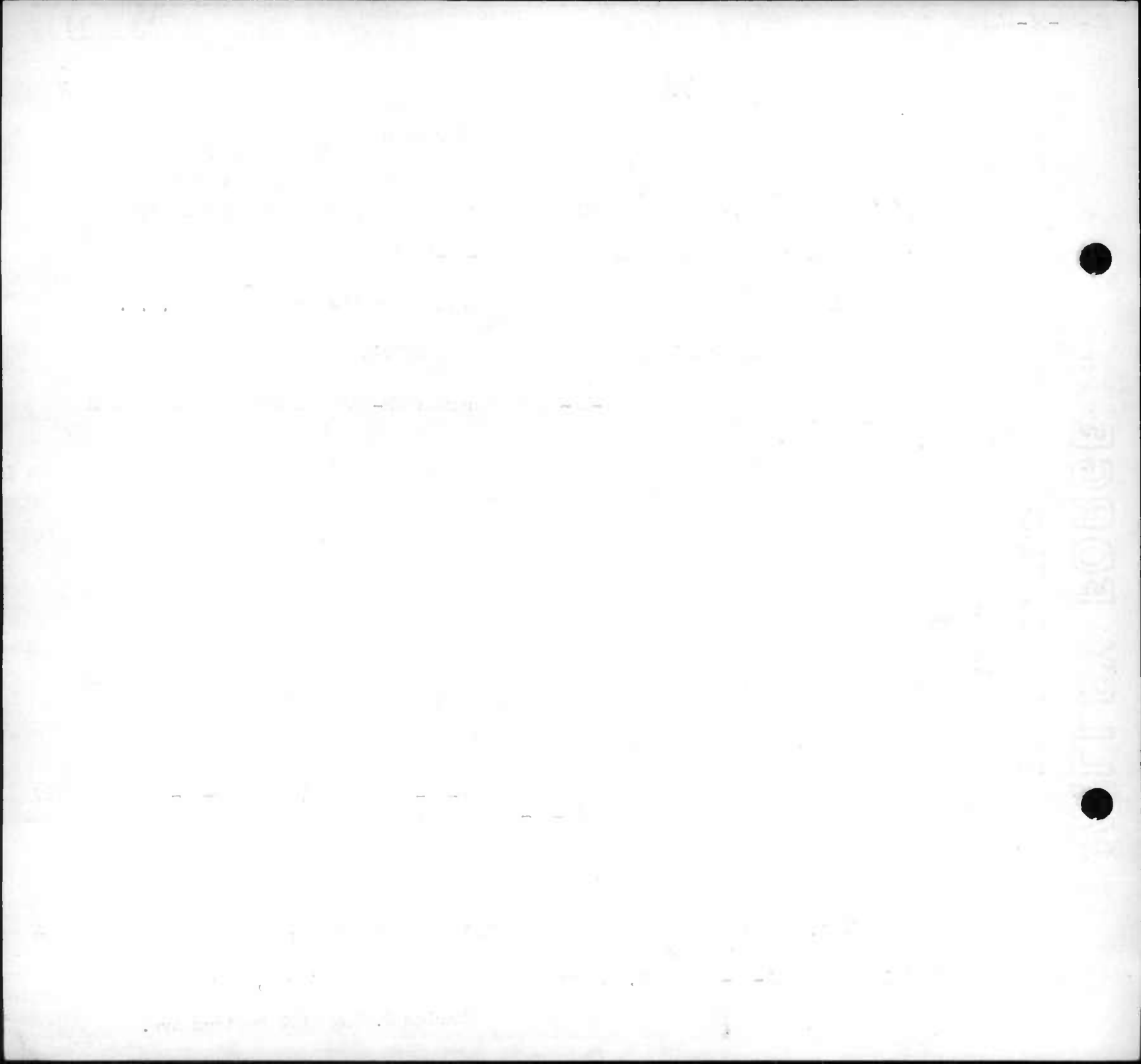
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 11083		CERTIFICATE OF DEATH		67 11083	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		THOMPSON, ALLIEN		11-18-67 1:35 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  46 Lutheran Hosp of Md.				A. STATE Md.	
				B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 16 15-04	
				D. STREET ADDRESS (If rural, give location) 2004 N. Smallwood St.	
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8-5-01	9. AGE (In years last birthday) 66	10. Under 1 Yr. Months Days 11 Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Laurin S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Madden			14. MOTHER'S MAIDEN NAME Ida King		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None	17. INFORMANT ADDRESS Elise Gross, 2004 Smallwood St.		
18. 443X1 CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) Subarachnoid hemorrhage 13 hrs + DUE TO (B) Hypertension ? DUE TO (C) Arteriosclerotic Cardio. ? Vascular Disease		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (✓) (this hospital) attended the deceased from 11-17 19 67 to 11-18 19 67, that (✓) (we) last saw the deceased alive on 11-17 19 67 and that in (✓) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (✓) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 11-18-67	
23C. PHYSICIAN'S NAME (Type) M.D.				23D. ADDRESS Lutheran Hosp M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-22-67		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE RECEIVED BY HEALTH DEPT. NOV 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Charles R. Law, 802 Madison Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-350		67 11084		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11084	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>MAGGIE W. PATTON</b>				2. DATE AND HOUR OF DEATH <b>11/18/67</b> <b>7<sup>15</sup> A</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>				A. STATE <b>Maryland</b>			
CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>				D. STREET ADDRESS (If rural, give location) <b>1016 West Lanvale Street</b> <b>21217</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b> (specify)		8. DATE OF BIRTH <b>9-28-1898</b>	9. AGE (In years last birthday) <b>69</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Walter Wilson</b>			
14. MOTHER'S MAIDEN NAME <b>Sylvia</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>219-12-6595</b>				17. INFORMANT ADDRESS <b>Records: BCH-4940 Eastern Avenue 21224</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Renal Failure</b> <b>Carcinoma - Cervix</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10-17-</b> 19 <b>67</b> to <b>11-18-</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-18-</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>David E. McBeth</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/18/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>David E. McBeth</b>				23D. ADDRESS M.D. <b>4940 Eastern Avenue, Baltimore, Maryland 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-22-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>NOV 20 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Charles R. Law</b>		ADDRESS <b>802 Madison Ave.</b>	



BIRTH NO.

M.E. CASE NO.

## 1. NAME OF DECEASED

(Type or Print)

JAMES

C.

GASKINS

## 2. DATE AND HOUR PRONOUNCED DEAD

November 18, 1967

4:45 P. M.

## 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 2923 Gwynn Falls Parkway

## 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)

A. STATE

Maryland

B. COUNTY

## C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

## D. STREET ADDRESS (If rural, give location)

2923 Gwynn Falls Parkway

## 5. SEX

Male

## 6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

## 8. DATE OF BIRTH

Oct. 19, 1908

9. AGE (In years  
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Teacher

## 10B. KIND OF BUSINESS OR INDUSTRY

Baltimore City

## 11. BIRTHPLACE (State or foreign country)

NewPort News, Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Phillip Gaskins

## 14. MOTHER'S MAIDEN NAME

Hattie Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

219-18-5673

## 17. INFORMANT

## ADDRESS

Rosa T. Gaskins - 2923 Gwynns Falls Pkwy.

## 18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Cranio-cerebral injury

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Hypertensive Cardiovascular Disease

MEDICAL CERTIFICATION

## 19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

## 20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

2923 Gwynn Falls Parkway

21D. TIME  
OF INJURY  
(APPROX.)

11/18/67 3:30 P.

## 21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

## 21F. HOW DID INJURY OCCUR?

Presumably fell

## 22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

11/19/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

## 23B. DATE

11-24-67

## 23C. NAME OF CEMETERY or CREMATORY

Arbutus Memorial Park

## 23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

## 24A. DATE REC'D BY HEALTH DEPT.

NOV 20 1967

## 24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

## 24C. FUNERAL DIRECTOR

Charles R. Law 802 Madison Ave.

## ADDRESS

WILLIAM

FRIG



1  
K-400

67 11086 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11086

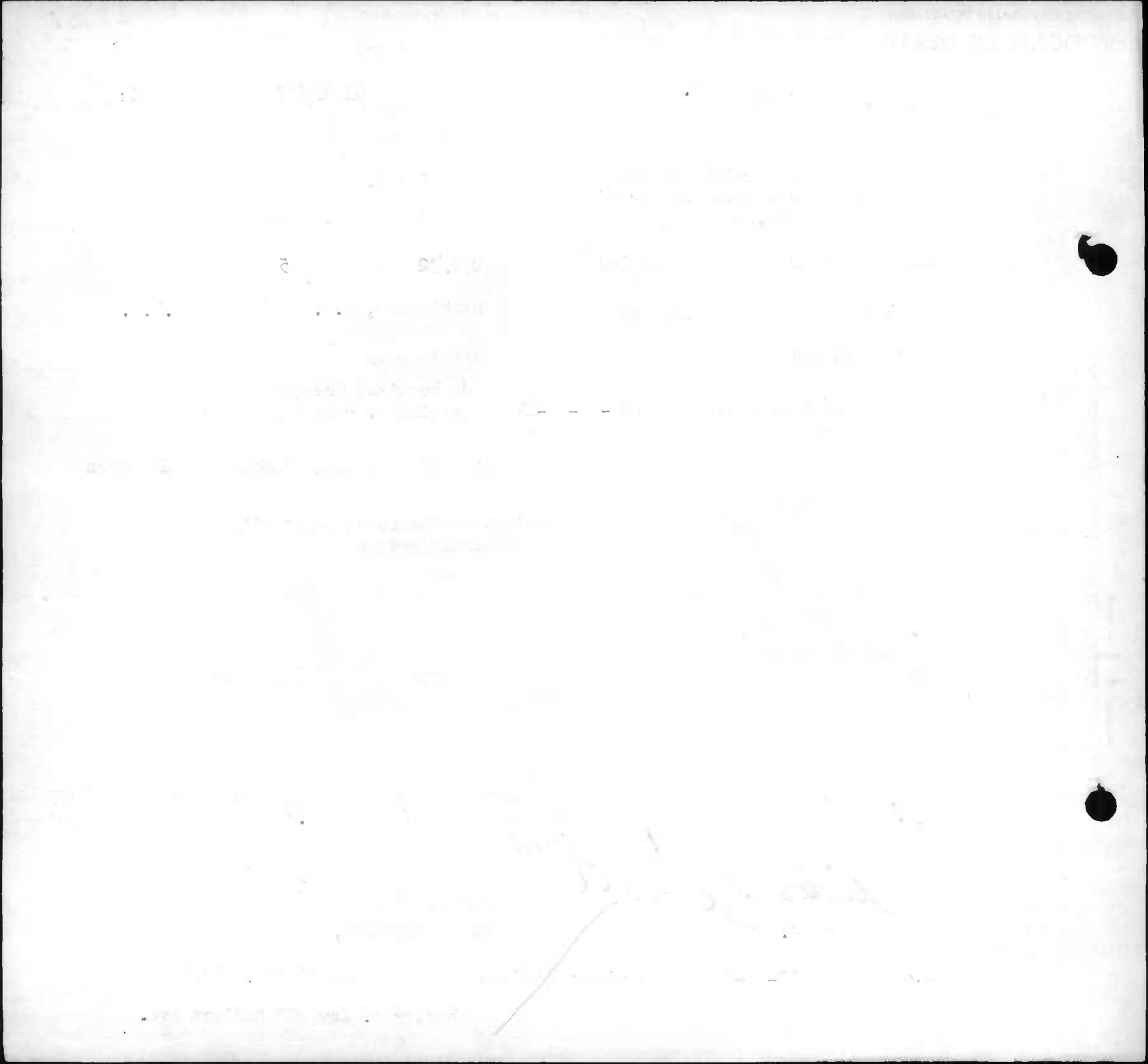
BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <b>NORMAN KELLY</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>November 15, 1967   6:30 a. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>University Hospital</b> <b>12-11-67</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) <b>Maryland</b> <b>Baltimore</b> <b>1803</b> <b>109 S. Stockton St.</b>	
5. SEX <b>Male</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>12-29-1925</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>41</b>
11. BIRTHPLACE (State or foreign country) <b>Simpsonville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Royal N. Kelly</b>		14. MOTHER'S MAIDEN NAME <b>Nora Lavenia Dorsey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Charles A. Kelly - 4103 Stokes Drive</b>		ADDRESS	
18. CAUSE OF DEATH <b>Subdural and epidural hematoma</b>		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Unknown</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Unknown</b>		21D. TIME OF INJURY (APPROX.) <b>Unknown</b>	
21E. INJURY OCCURRED <b>Unknown</b>		21F. HOW DID INJURY OCCUR? <b>Unknown</b>	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> <del>Undetermined manner <input checked="" type="checkbox"/></del>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>11-21-67</b>	
23C. NAME of CEMETERY or CREMATORY <b>Baltimore National</b>		23D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>NOV 20 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Farley</b>	
24C. FUNERAL DIRECTOR <b>Charles R. Law</b>		ADDRESS <b>802 Madison Ave.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

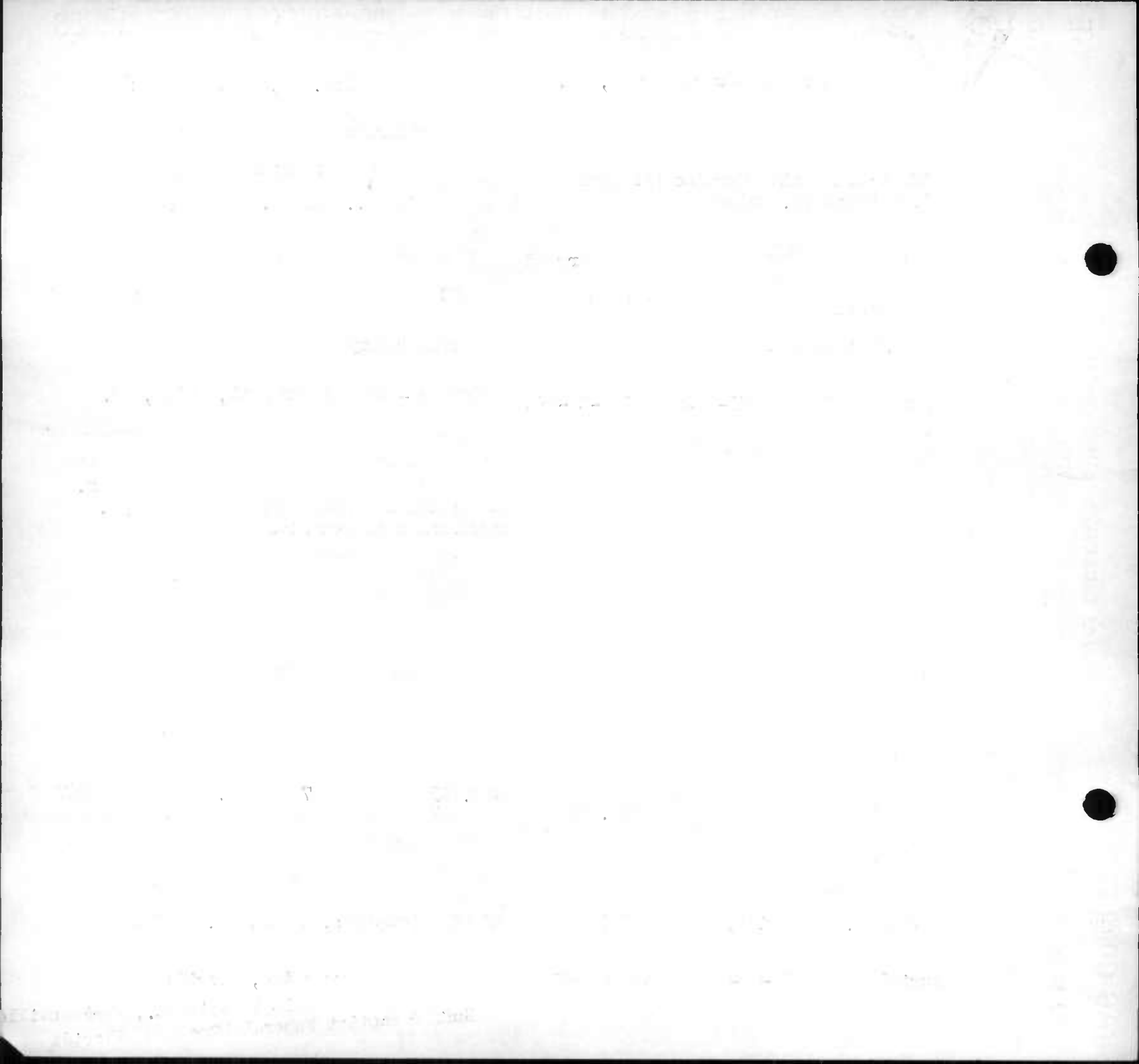
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. _____	
BIRTH NO. <b>67 11087</b>		<b>CERTIFICATE OF DEATH</b>		Registered No. <b>67 11087</b>	
M.E. CASE NO. _____			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>BARNES, EDWARD P.</b>			11/14/67 11:35 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Md 21218</b>			A. STATE <b>Maryland</b> B. COUNTY _____		
C. CITY OR TOWN (If outside city limits, give rural and give township) <b>Baltimore</b>			D. STREET ADDRESS (If rural, give location) <b>4829 Beauford Ave</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>2/1/32</b>	9. AGE (In years last birthday) <b>35</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Aide</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Rosewood</b>	11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles Barnes</b>			14. MOTHER'S MAIDEN NAME <b>Agnes Brown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 6/61 to 6/64</b>		16. SOCIAL SECURITY NO. <b>578-38-98-17</b>	17. INFORMANT <b>VA Hospital Records Baltimore, Maryland 21218</b>		ADDRESS _____
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Disseminated Sarcoidosis</b>					<b>12 years</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Pulmonary atherosclerosis with arterosclerosis</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>November 14th 19 67</b> to <b>November 14th 19 67</b> , that (I) (we) last saw the deceased alive on <b>November 14th 19 67</b> and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.					
23A. SIGNATURE  M.D.					23B. DATE SIGNED <b>11/15/67</b>
23C. PHYSICIAN'S NAME (Type) <b>RICHARD J. OWELLEN</b>			23D. ADDRESS <b>VAH BALTIMORE, MD 21218</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>11-20-67</b>	24C. NAME of CEMETERY or CREMATORY <b>Baltimore National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 20 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>Charles R. Law 802 Madison Ave.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

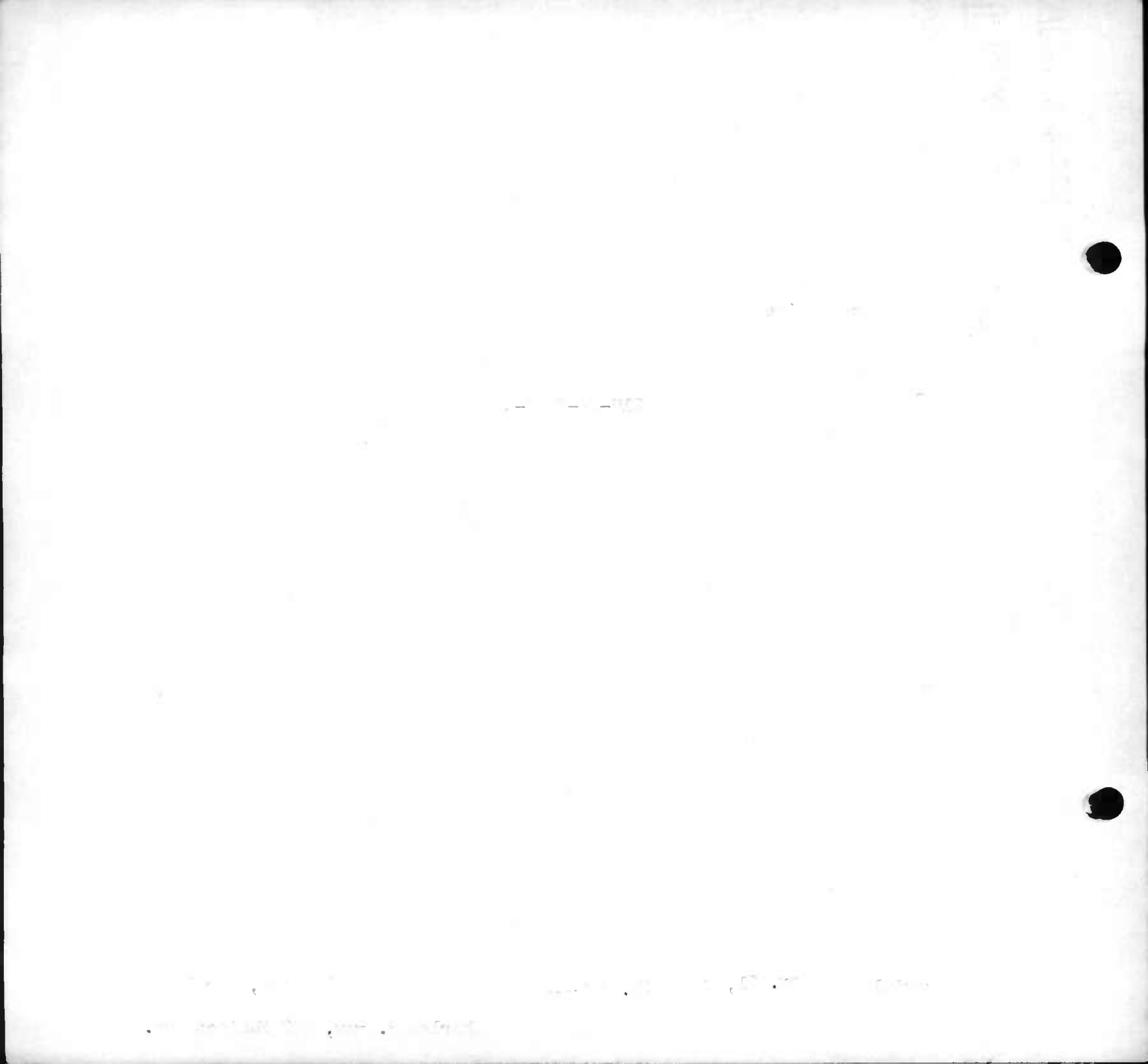
BIRTH NO.		67 11088		BALTIMORE CITY HEALTH DEPARTMENT		Certificate of Death		Registered No. 67 11088	
1. NAME OF DECEASED (Type or Print) <b>Charles Edward Harris, Sr.</b>				2. DATE AND HOUR OF DEATH <b>Nov. 15, 1967</b>		2:20 P		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>US Public Health Service Hospital 3100 Wyman Pk. Drive</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Florida</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Fernandina Beach</b> D. STREET ADDRESS (If rural, give location) <b>418 S. Ninth St.</b>					
5. SEX <b>M</b>	6. RACE <b>Col</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>8/16/17</b>	9. AGE (In years last birthday) <b>50</b>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Seafarer</b>		11. BIRTHPLACE (State or foreign country) <b>NC</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>James Harris</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Bailey</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes USN 1943-1945</b>		16. SOCIAL SECURITY NO. <b>266-05-6448</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>150 X I</b> <b>Heart failure</b> <b>Esophageal squamous cell carcinoma with metastases</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>Terminal</b> <b>Approx. 1 yr.</b>			
19. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (If (this hospital) attended the deceased from <b>Aug. 13</b> 19 <b>67</b> to <b>Nov. 15</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Nov. 15</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>John A. Kibelstis</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/17/67</b>			
23C. PHYSICIAN'S NAME (Type) <b>John A. Kibelstis, Surgeon (R)</b>				23D. ADDRESS M.D. <b>US PHS Hospital, Balto, Md. 21211</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-22-67</b>		24C. NAME of CEMETERY or CREMATORY <b>Bosque Bello</b>		24D. LOCATION (City, town, or county) (State) <b>Fernandina, Florida</b>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Huff &amp; Baptist Funeral Home</b>		ADDRESS <b>1337 Davis St., Jacksonville Florida</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11089		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11089	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>BROWN, WILLIE MAE LEE</u>		2. DATE AND HOUR OF DEATH <u>NOV. 16, 1967</u> <u>12:55 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give town/ship) <u>BALTIMORE</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>36 FRANKLIN SQUARE Hospital</u>		D. STREET ADDRESS (If rural, give location) <u>22 NORTH CAREY ST.</u>			
5. SEX <u>F</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>W</u>	8. DATE OF BIRTH <u>7-29-93</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOHN JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>MARY HALCY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-20-5983-A</u>		17. INFORMANT <u>FRANKLIN SQUARE HOSPITAL</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Softening</u> <u>CVA</u>		CAUSE OF DEATH (A) DUE TO <u>Cerebral Softening</u> (B) DUE TO <u>Massive &amp; I. Bleeding</u> (C)		INTERVAL BETWEEN ONSET AND DEATH <u>(?)</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 12, 1967</u> to <u>NOVEMBER 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>NOV. 16, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ruben V. Lura</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>11-16-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>RUBEN V. LURA</u>		M.D. 23D. ADDRESS <u>FRANKLIN SQUARE HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Nov. 21, 67</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 20 1967</u>		25B. NAME OF REGISTRAR <u>Charles E. Farley</u>		25C. FUNERAL DIRECTOR <u>Charles R. Law, 802 Madison Ave.</u>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
67 11090					CERTIFICATE OF DEATH					Registered No. 67 11090									
BIRTH NO.										M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <b>WILLIE RhONE</b>										2. DATE AND HOUR OF DEATH <b>11-17-67 9:30 A</b> M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>001406 E. Biddle ST</b>										A. STATE <b>MD</b> B. COUNTY									
										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO. 10-01</b>									
										D. STREET ADDRESS (If rural, give location) <b>1406 E. Biddle ST</b>									
5. SEX <b>M</b>		6. RACE <b>C.</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>6-10-10</b>		9. AGE (In years last birthday) <b>57</b>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CIRCULATOR</b>										10B. KIND OF BUSINESS OR INDUSTRY <b>AMERICAN SMELTING</b>									
11. BIRTHPLACE (State or foreign country) <b>S.C.</b>										12. CITIZEN OF WHAT COUNTRY?									
13. FATHER'S NAME <b>Jim Rhone</b>										14. MOTHER'S MAIDEN NAME <b>Emma McFadden</b>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>										16. SOCIAL SECURITY NO.									
17. INFORMANT <b>JAMES RhONE 1029 FREMANS N.Y.C.</b>										ADDRESS									
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>260X1</b>										CAUSE OF DEATH (A) <b>Hypertension Heart Disease</b> DUE TO (B) <b>Diabetes Mellitus</b> DUE TO (C)									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION <b>D</b>										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20A. AUTOPSY? (Yes or No)										20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)									
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)																			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)										21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
21F. HOW DID INJURY OCCUR?																			
22. I certify that (I) (this hospital) attended the deceased from <b>10-19</b> 19 <b>65</b> to <b>11/17</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>7/28</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE <b>Bernard Harris Sr.</b> M.D.										23B. DATE SIGNED <b>11/20/67</b>									
23C. PHYSICIAN'S NAME (Type) <b>Bernard Harris Sr.</b> M.D.										23D. ADDRESS									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>REMOVAL</b>										24B. DATE <b>11/20/67</b>									
24C. NAME OF CEMETERY or CREMATORY <b>Redspring N.C.</b>										24D. LOCATION (City, town, or county) (State)									
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 20 1967</b>										25B. NAME OF REGISTRAR <b>Joseph L. Rock Jr.</b>									
25C. FUNERAL DIRECTOR <b>13047 Central Ave</b>										ADDRESS									

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67, 11091 BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. *San Antonio, Tex.* MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11091

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>BRIAN LITTLE</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>November 17, 1967</b>   <b>12:30 p.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>8-05</b> D. STREET ADDRESS (If rural, give location) <b>1625 E. North Ave.</b>			
5. SEX <b>Male</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Child</b>	8. DATE OF BIRTH <b>8-20-64</b>		9. AGE (In years last birthday) <b>3</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>SAN ANTONIO TEXAS</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Robert E. Little</b>				14. MOTHER'S MAIDEN NAME <b>Nozelle Roberts</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Nozelle Roberts</b> ADDRESS <b>1625 E. North Ave</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>E 816.4</b> <b>Multiple traumatic injuries</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) DUE TO</b> <b>(B) DUE TO</b> <b>(C) DUE TO</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Asquith St. 57 ft. N. of Eager St.</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>11 11 67 4:35p.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Pedestrian struck by auto</b> <b>10-01</b>			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>November 17, 1967</b>							
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>11/21/67</b>		23C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. PK.</b>		23D. LOCATION (City, town, or county) (State) <b>Arbutus Md</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>NOV 20 1967</b>		24B. NAME OF REGISTRAR <b>D. O. G. E. F. J. J. J.</b>		24C. FUNERAL DIRECTOR <b>Joseph B. Locks</b>		ADDRESS <b>1304 N. Central</b>	

8-20-64  
San Antonio, Texas  
Miguel Roberts  
Miguel Roberts 1925

Child  
Name  
Robert F. Little  
No.

Bureau of Census

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CASE RELEASED ON APPROVAL BY DR. CONTABLOS OF MEDICAL EXAMINER'S OFFICE

BIRTH NO. 67 11092		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11092	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <b>WENDELL GREEN</b>		
2. DATE AND HOUR OF DEATH <b>11/18/67 2:30 A.M.</b>			3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>JOHNS HOPKINS HOSPITAL</b>		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>USA</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 9-09</b>		
D. STREET ADDRESS (If rural, give location) <b>1313 E. FEDERAL ST.</b>			FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>JOHNS HOPKINS HOSPITAL</b>		
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>5/13/22</b>	9. AGE (In years last birthday) <b>45</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>			11. BIRTHPLACE (State or foreign country) <b>Balt. Md</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>WILLIAM GREEN</b>		
14. MOTHER'S MAIDEN NAME <b>EMMA ASKINS</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Alma HARRIS 1313 E. Federal Ave</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>Cardiac arrhythmia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 HRS</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Anemia</b>			?		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>299 bleed</b>			?		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/17</b> 19 <b>67</b> to <b>11/18</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11/18</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harry K Genant</b>				23B. DATE SIGNED <b>11/18/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>HARRY K. GENANT</b>				23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/22/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus mem PK</b>	
24D. LOCATION (City, town, or county) (State) <b>Arbutus 17th</b>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>Joseph J. ... 1304 ...</b>			

Highland  
with a view of  
the river and  
the mountains

Donegal

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.


BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 11093</u>	
67 11093				CERTIFICATE OF DEATH	
BIRTH NO. <u>67 11093</u>				M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <u>Frank M. Andrews</u>				2. DATE AND HOUR OF DEATH <u>11-17-67</u> <u>4:00 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore Co</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>53-00</u> D. STREET ADDRESS (If rural, give location) <u>8023 Duval Ave.</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. <del>MARRIED</del> NEVER MARRIED <u>WIDOWED</u> , DIVORCED (specify)	8. DATE OF BIRTH <u>11-24-83</u>	9. AGE (In years lost birthday) <u>83</u>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Stanley Andrews</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>217-04-4213</u>		17. INFORMANT <u>Daughter (Clara Brannock)</u>
18. <u>420.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>I</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH <u>1. Anterolateral Heart Disease</u> DUE TO <u>2. Anemia, severe</u> DUE TO (C) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>NO.</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>11-7-67</u> to <u>11-17-67</u> , that (I) (we) last saw the deceased alive on <u>11-17-67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William L. Boddie</u>				23B. DATE SIGNED <u>11-17-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>—</u>				23D. ADDRESS M.D. <u>Maryland General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/20/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Sacred Heart of Jesus</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 20 1967</u>			
25B. NAME OF REGISTRAR <u>—</u>		25C. FUNERAL DIRECTOR <u>George R. Weber</u>			
25D. ADDRESS <u>705 S. Ann St</u>					

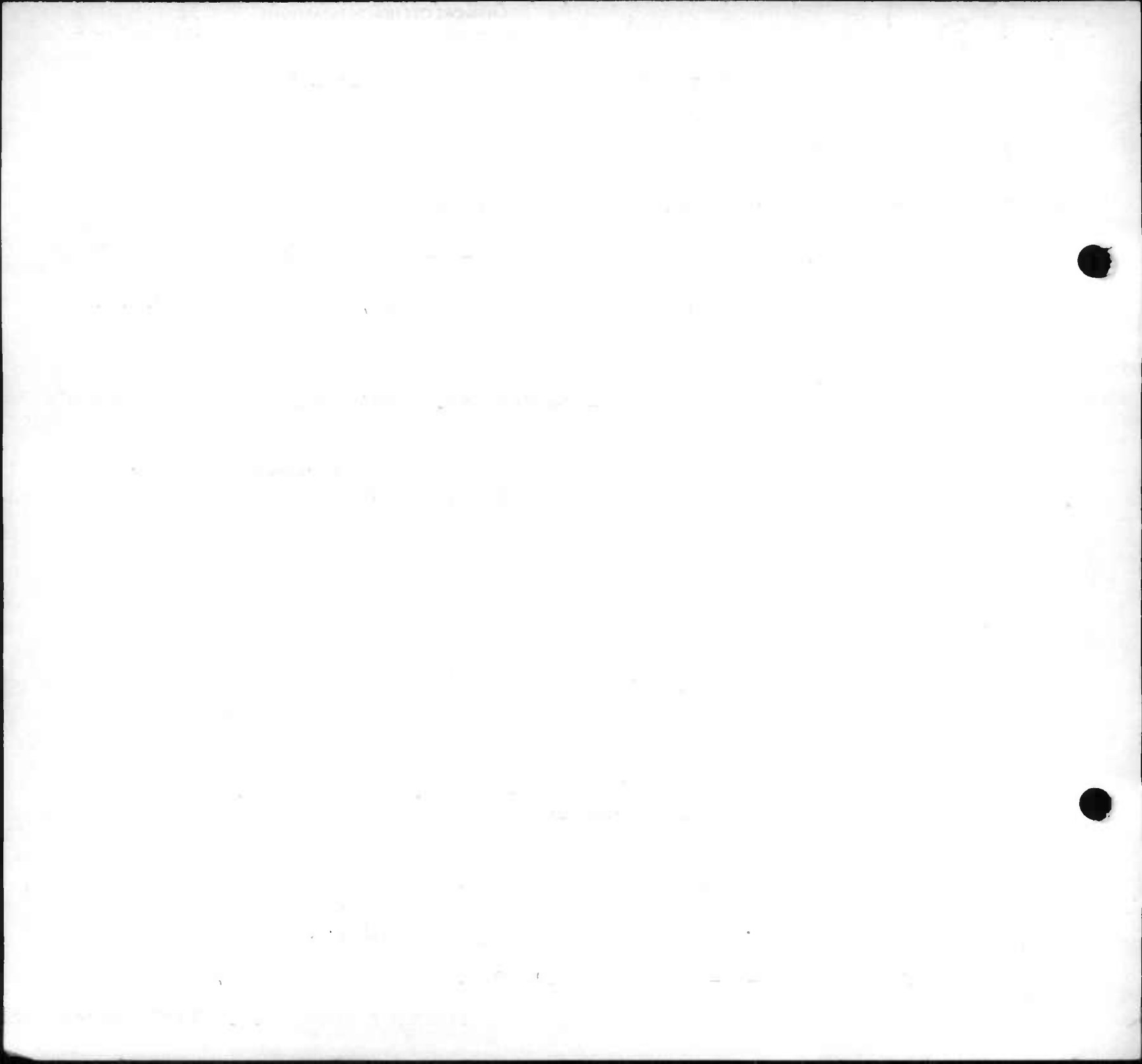
Charles A. Wilson, Jr. & Son  
11/20/67 Special Agent of Police, Baltimore, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

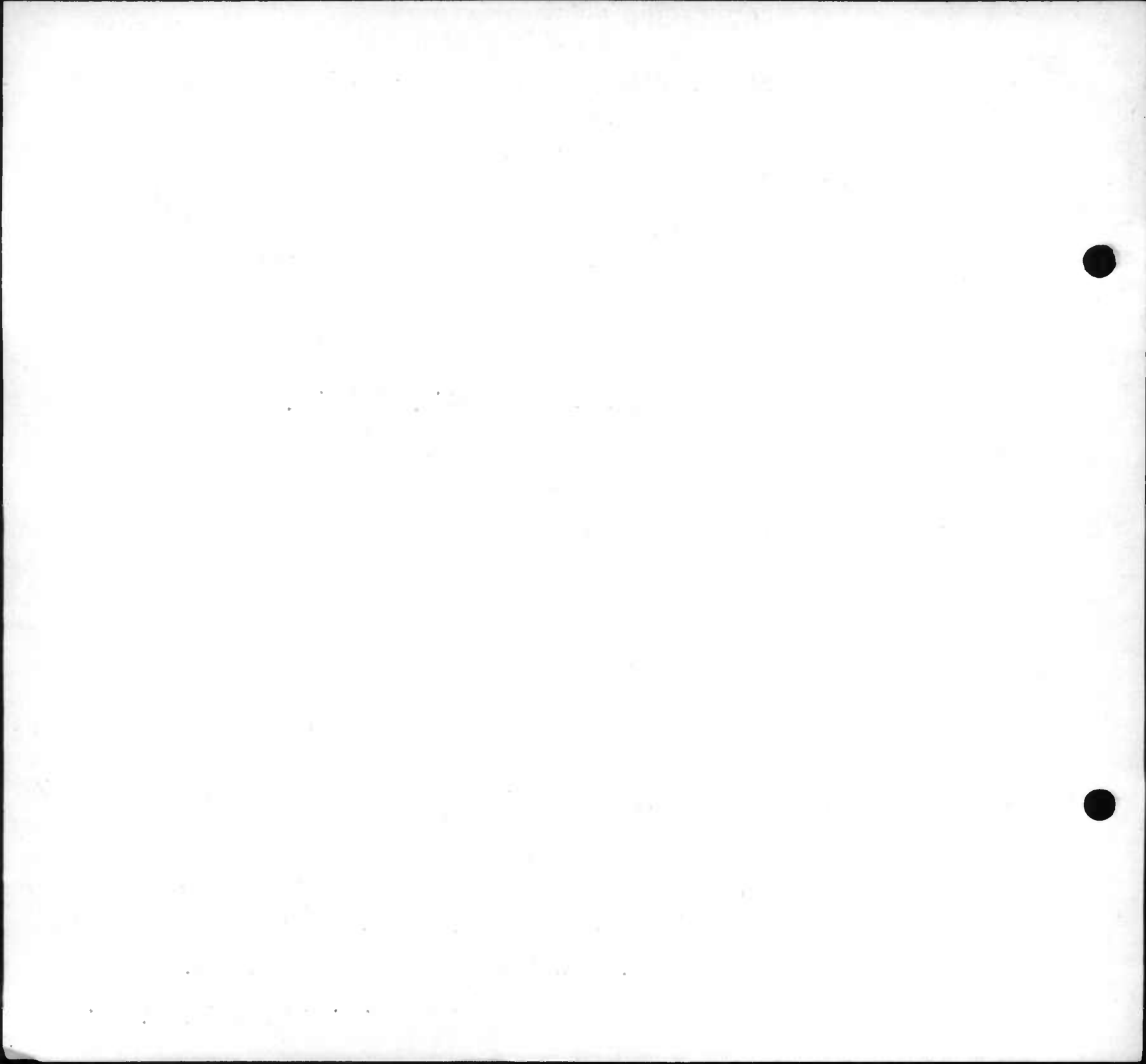
BALTIMORE CITY HEALTH DEPARTMENT			
67 11094		CERTIFICATE OF DEATH	
BIRTH NO.		Registered No. 67 11094	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
EDWARD JAMES SMITH		11-16-67	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION  3928 Cederdale Road		A. STATE MARYLAND B. COUNTY BALTIMORE	
5. SEX M.		6. RACE N.	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 6-24-1915	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
SHIPPING CLERK		BALTIMORE, MARYLAND	
13. FATHER'S NAME WILLIAM J. SMITH		14. MOTHER'S MAIDEN NAME ALVERTA JONES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-05-8569	
17. INFORMANT Mrs. Bessie Hall		ADDRESS 3928 Cederdale Rd	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenio, etc. It means the disease, injury or complication which caused death.)  150X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  CAUSE OF DEATH (A) Epidermoid Carcinoma of Esophagus DUE TO With metastases (B) _____ DUE TO _____ (C) _____  INTERVAL BETWEEN ONSET AND DEATH unknown			
19. DATE OF OPERATION June, 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Esophageal obstruction	
20A. AUTOPSY? (Yes or No) None		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from September, 1967 to November 16, 1967, that (I) (we) lost saw the deceased olive on November 16, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED November 17, 1967	
23C. PHYSICIAN'S NAME (Type) Ernest O. Brown		23D. ADDRESS 3414 Duvall Avenue Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-20-67	
24C. NAME OF CEMETERY or CREMATORY BALTO NAT'L CEM.		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. NOV 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 11095</u>	
CERTIFICATE OF DEATH					
BIRTH NO. <u>5-315</u>		67 11095			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>Stevens, Mary Ellen</u>			2. DATE AND HOUR OF DEATH <u>11-18-67.</u> <u>1:10 P.</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bon Secours Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>525 N. Loudon Ave.</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec. 28 1898</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			13. FATHER'S NAME <u>William Stevens</u>		
14. MOTHER'S MAIDEN NAME <u>Rosemary Lynch</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u>		
16. SOCIAL SECURITY NO. <u>215-22-6448</u>			17. INFORMANT <u>Mr. Herbert E. Stevens</u> <u>525 N. Loudon Ave.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osseous, etc. It means the disease, injury or complication which caused death.) <u>A.S.C.V.D. AND DIABETIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u> <u>YEARS</u>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 16</u> 19 <u>67</u> to <u>Nov 18</u> 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>Nov. 18</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Agustin del Campo</u>			M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Nov. 18-1967</u>
23C. PHYSICIAN'S NAME (Type) <u>AGUSTIN DEL CAMPO</u>			23D. ADDRESS <u>BON SECOURS HOSP. BALT. MD</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <u>St. Aloysius Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Cresson, Penn.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 20 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Witzke F. D.</u> ADDRESS <u>4101 Edmondson Ave. Baltimore, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 11096</u>	
67 11096				67 11096	
BIRTH NO.				M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <b>HUFF STELLA ELSIE</b>			2. DATE AND HOUR OF DEATH <b>NOVEMBER 17, 1967 12:10 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  <b>ST. AGNES HOSPITAL WILKENS AND CATON AVENUE BALTIMORE MARYLAND 21229</b>  <b>40</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2008</b>		
5. SEX <b>FEMALE</b>			6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>
8. DATE OF BIRTH <b>09/13/59</b>		9. AGE (In years last birthday) <b>8</b>		10. Under 1 Yr. Months Days Hours Min. <b>11 Under 24 Hrs. Min.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>VIRGIL</b>			14. MOTHER'S MAIDEN NAME <b>OLSON</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Virgil Huff, Jr. - 112 S. Augusta Av. ST AGNES HOSPITAL WILKENS &amp; CATON</b>
18. <b>204.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <b>Acute Lymphatic Leukemia</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>OCTOBER 26</b> 19 <b>67</b> to <b>NOVEMBER 17</b> 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>NOVEMBER 17</b> 19 <b>67</b> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11/17/67</b>
23C. PHYSICIAN'S NAME (Type) <b>JOHN WEAGLY</b>			23D. ADDRESS M.D. <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVE.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/20/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cem.</b>	
24D. LOCATION <b>Baltimore, Md.</b>		24E. NAME OF REGISTRAR <b>Robert E. Farkley</b>		25C. FUNERAL DIRECTOR <b>Witzke F. D. - 4101 Edmondson Ave.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 20 1967</b>		25B. NAME OF REGISTRAR		25D. ADDRESS	

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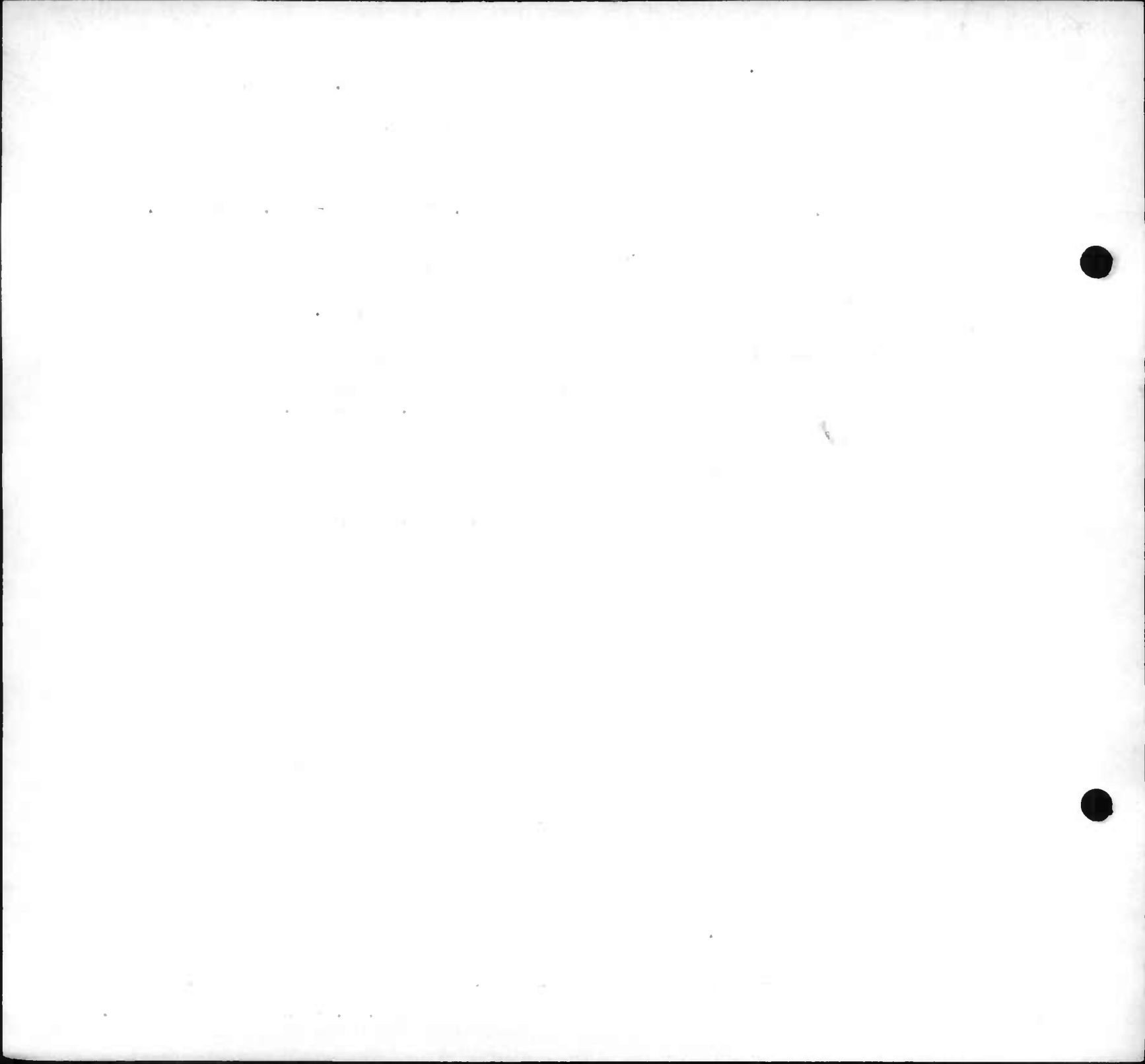
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>W-260 67 11097</p> <p>BIRTH NO. 67 11097</p>		<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>Registered No. 67 11097</p>	
<p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <i>L. Anne Wacker</i></p>			<p>2. DATE AND HOUR OF DEATH</p> <p><i>Nov. 18, 1967</i></p>		
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p><i>90 General German Aged Home</i> <i>22 S. Athol Avenue</i></p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <i>Md</i> B. COUNTY <i>28-04</i></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i></p> <p>D. STREET ADDRESS (If rural, give location) <i>Gen. German Home-22 S. Athol Ave.</i></p>		
<p>5. SEX <i>F</i></p>	<p>6. RACE <i>Wh</i></p>	<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i></p>	<p>8. DATE OF BIRTH <i>5/4/79</i></p>	<p>9. AGE (In years last birthday) <i>88</i></p>	<p>If Under 1 Yr. Months: Days: Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i></p>			<p>11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i></p>		<p>12. CITIZEN OF WHAT COUNTRY? <i>USA</i></p>
<p>13. FATHER'S NAME <i>John Fischer</i></p>			<p>14. MOTHER'S MAIDEN NAME <i>Katherine Steil</i></p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p>	<p>17. INFORMANT <i>General German Home</i> <i>22 S. Athol Ave.</i></p>		
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>			<p>CAUSE OF DEATH</p> <p>(A) <i>Acute Cardiac Decompensation</i></p> <p>(B) <i>Arteriosclerotic Myocardial</i></p> <p>(C) <i>Degeneration</i></p>		
<p>19A. DATE OF OPERATION</p>			<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		
<p>20A. AUTOPSY? (Yes or No)</p>			<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>			<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>		
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>			<p>21F. HOW DID INJURY OCCUR?</p>		
<p>22. I certify that (I) (this hospital) attended the deceased from <i>5 Nov 1967</i> to <i>18 Nov 1967</i>, that (I) (we) last saw the deceased alive on <i>18 Nov 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <i>William J. Bryson</i></p>			<p>23B. DATE SIGNED <i>18 Nov 67</i></p>		
<p>23C. PHYSICIAN'S NAME (Type) <i>William J. Bryson</i></p>			<p>23D. ADDRESS <i>M.D.</i></p>		
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i></p>		<p>24B. DATE <i>11/21/67</i></p>	<p>24C. NAME OF CEMETERY or CREMATORY <i>Loudon Park Cem.</i></p>		<p>24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i></p>
<p>25A. DATE REC'D BY HEALTH DEPT. <i>NOV 20 1967</i></p>		<p>25B. NAME OF REGISTRAR <i>Robert E. Farber</i></p>		<p>25C. FUNERAL DIRECTOR ADDRESS <i>Witzke F. D. - 4101 Edmondson Ave.</i></p>	

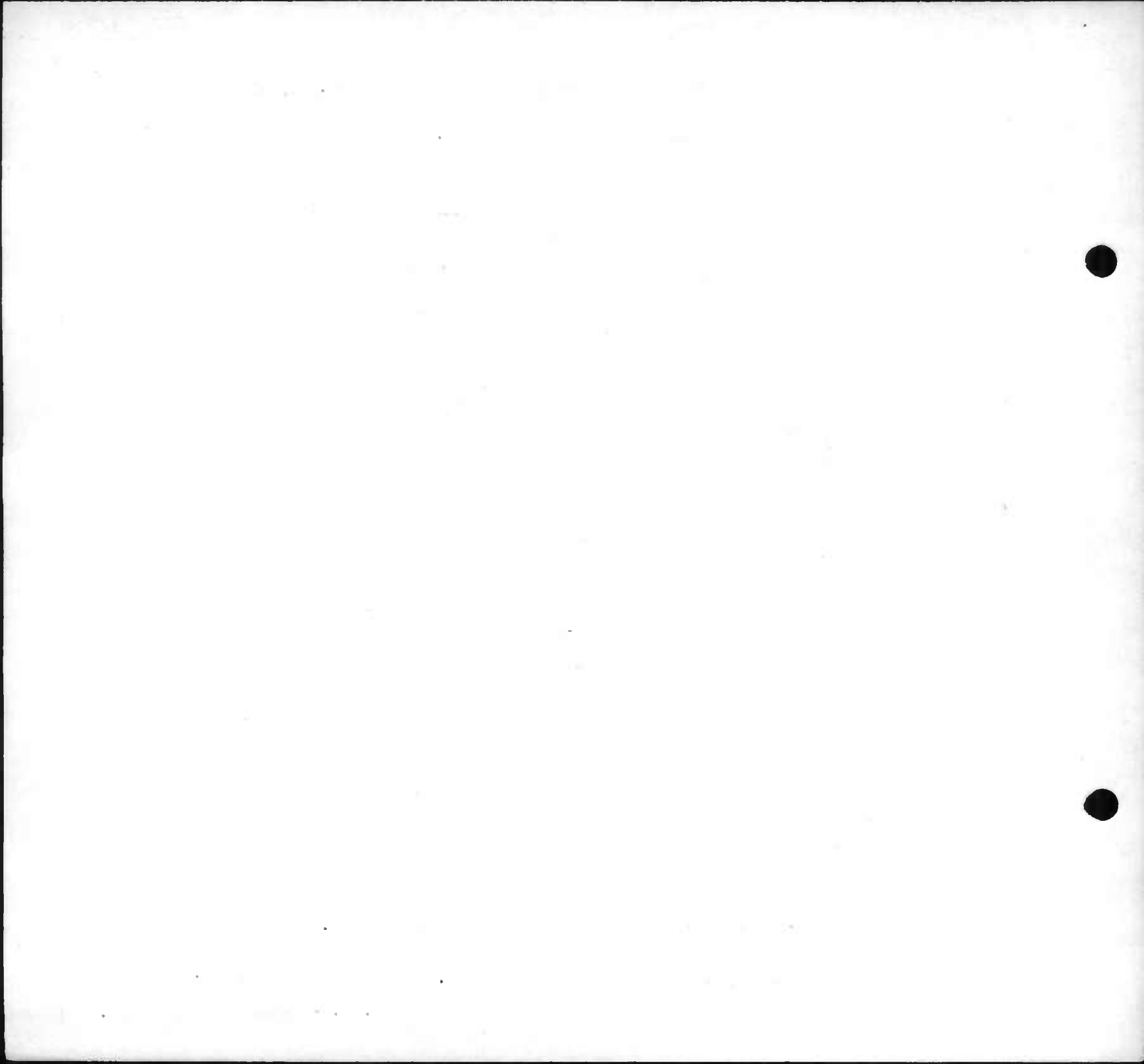




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67-11098	
BIRTH NO. 67 11098							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <b>Cosima Giordano</b>				2. DATE AND HOUR OF DEATH <b>Nov. 17/67</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1110 Cooks Lane</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>28-04</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>1110 Cooks Lane</b>			
5. SEX <b>F</b>	6. RACE <b>Wh</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>2/14/88</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Vincent Papa</b>				14. MOTHER'S MAIDEN NAME <b>Maryann Carnaiggo</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Joseph Giordano</b> <b>1110 Cooks Lane</b>		ADDRESS	
18. <b>422.1 + 260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ASCVD</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO			
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<b>Diabetes Mellitus</b>		<b>2 yrs</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>July 16</b> to <b>Nov 17</b> 19 <b>67</b> , that (I) <del>was</del> last saw the deceased alive on <b>Nov 14</b> 19 <b>67</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>not</del> view the body after death.							
23A. SIGNATURE <b>Earl Pass</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11-18-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>I. Earl Pass</b>				23D. ADDRESS M.D. <b>4001 Wilkens Ave.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/20/67</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 20 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Witzke F. D. - 4101 Edmondson Ave.</b>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11099</b>	
67 11099				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Richard Williams</b>	
2. DATE AND HOUR OF DEATH <b>11/17/67 14:35 A.M.</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>University Hospital</b>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Balto, City</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
D. STREET ADDRESS (If rural, give location) <b>715 Wilmet Ct</b>		5. SEX <b>M</b> 6. RACE <b>Negro</b> 7. MARRIED, NEVER MARRIED, WIDOWED, <b>DIVORCED</b> (Specify)			
8. DATE OF BIRTH <b>7-23-03</b> 9. AGE (In years last birthday) <b>64</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Richard Williams</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Taylor</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-14-7000</b>		17. INFORMANT <b>Lettie Wms. 3414 Auchenoroly Ter.</b>	
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Embolus</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Constrictive Heart Failure</b> <b>ASCAVD</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> <b>20 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/13</b> <b>1967</b> to <b>11/17</b> <b>1967</b> , that (I) (we) last saw the deceased alive on <b>11/17</b> <b>1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. E. Z. [Signature]</b>				23B. DATE SIGNED <b>11/17/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>University Hosp. Md.</b>				23D. ADDRESS <b>University Hosp. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/21/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 20 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Kelson Funeral Home 1348 Calhoun St.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 11100	
BIRTH NO. R-163		67 11100		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARTHA E. ROBERTSON		2. DATE AND HOUR OF DEATH 11-18-67 805 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO.		5. CITY OR TOWN (If outside city limits, write RURAL and give township) REISTERSTOWN. 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSP.		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 452 MAIN Street	
6. SEX F	7. RACE W	8. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	9. DATE OF BIRTH 8-22-87	10. AGE (In years last birthday) 80y.	11. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME WILLIAM DUNKLE		14. MOTHER'S MAIDEN NAME MARY BAKER		12. CITIZEN OF WHAT COUNTRY? USA.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-32-1197		17. INFORMANT P. CHT. ADDRESS	
18. 7337 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) ASCVD & Atrial Substitution		11/16 - 11/18/67	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Edematous Pancreatitis with			
		(C) Common Duct Obstruction			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 11/16/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute Abdomen		20A. AUTOPSY? (Yes or No) NO.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 11/16 1967 to 11/18 1967, that (we) last saw the deceased alive on 11/18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE David I. Schwartz		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/18/67	
23C. PHYSICIAN'S NAME (Type) DR DAVID SCHWARTZ		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/21/67		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery	
				24D. LOCATION (City, town, or county) Pikesville, Md. (State)	
25A. DATE REC'D BY HEALTH DEPT. NOV 20 1967		25B. NAME OF REGISTRAR Robert E. Farkema		25C. FUNERAL DIRECTOR J. F. Elmer & Sons Reisterstown, Md. ADDRESS	

REVEREND L. ROBERTSON - 11-12-01  
 BALTO MD  
 REISTERSTOWN  
 425 MAIN STREET  
 F W WIDOWED 8-22-81 BOY  
 MARYLAND  
 USA  
 WILLIAM DUNNICK  
 MARY BAKER  
 P. CH.

ACCORD 5 April 2000  
 (more Detail Attached)  
 (Continuation of previous)

11/10/13  
 Aunt Rebecca  
 N. O.

11/10/13  
 11/10/13  
 11/10/13

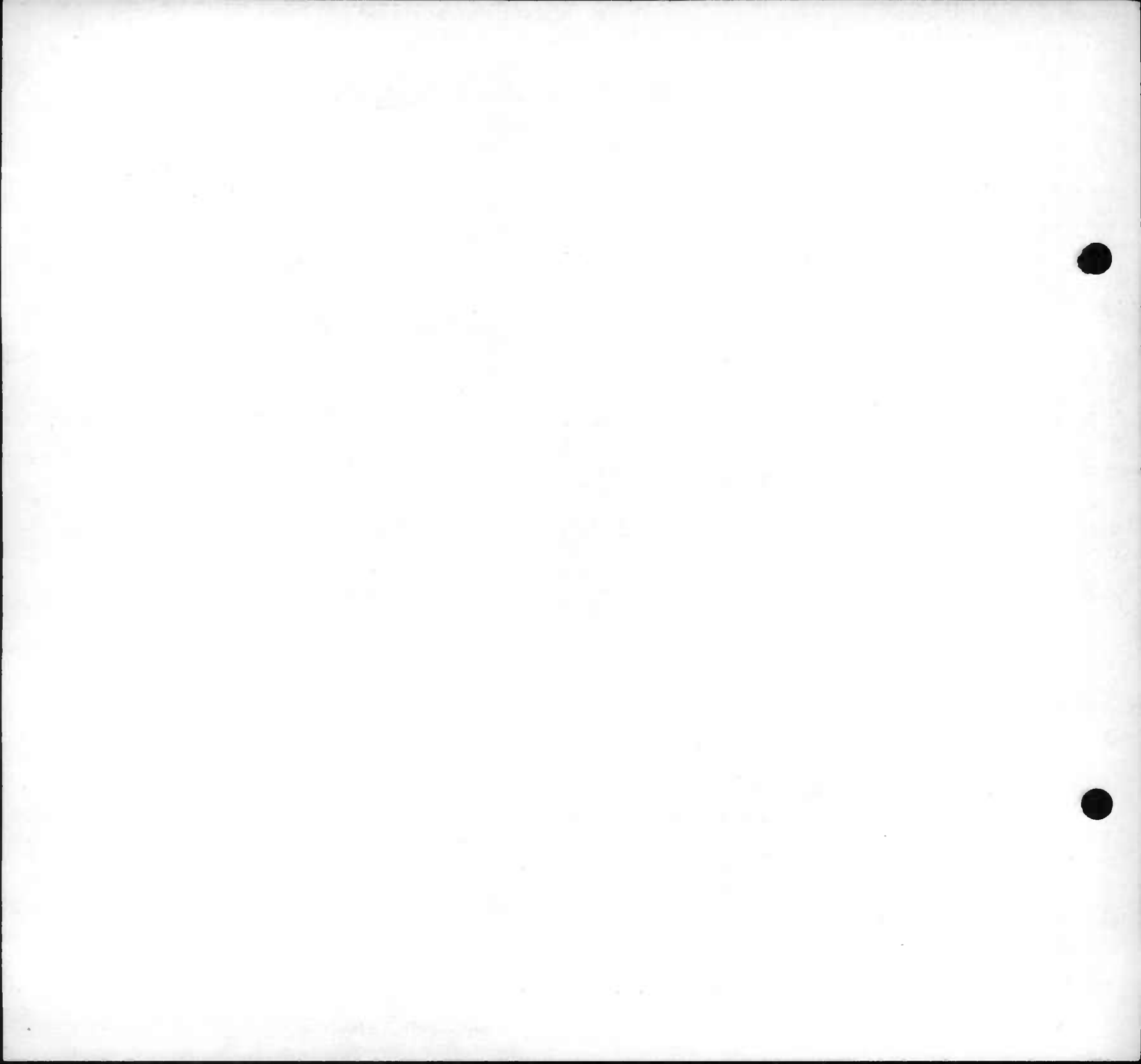
David & Deborah  
 11/10/13

Released by M.E. & Walter M.D.

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-200		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11101	
BIRTH NO. 67 11101		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Betty Rosco</i>		2. DATE AND HOUR OF DEATH <i>11-18-67 2 AM</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <i>General Hospital of Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		<i>15-13</i>	
		D. STREET ADDRESS (If rural, give location) <i>4160 Pimlico Road</i>			
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>12-20-02</i>	9. AGE (In years last birthday) <i>64</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME <i>Robert Branch</i>		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Luther Starks 4160 Pimlico Road</i>	
18. <i>420.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, give rise to the above cause (A) stating UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Myocardial Infarction</i>		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19A. DATE OF OPERATION		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11-18-67</i> to <i>11-18-67</i> , that (I) (we) last saw the deceased alive on <i>11-18-67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. <i>Deceased Deceased</i>					
23A. SIGNATURE <i>Harry Kretzman</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>11-18-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Harry Kretzman</i>		23D. ADDRESS <i>General Hospital of Balt.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-22-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 20 1967</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Kelson Funeral Home 1348 Calhoun St.</i>			

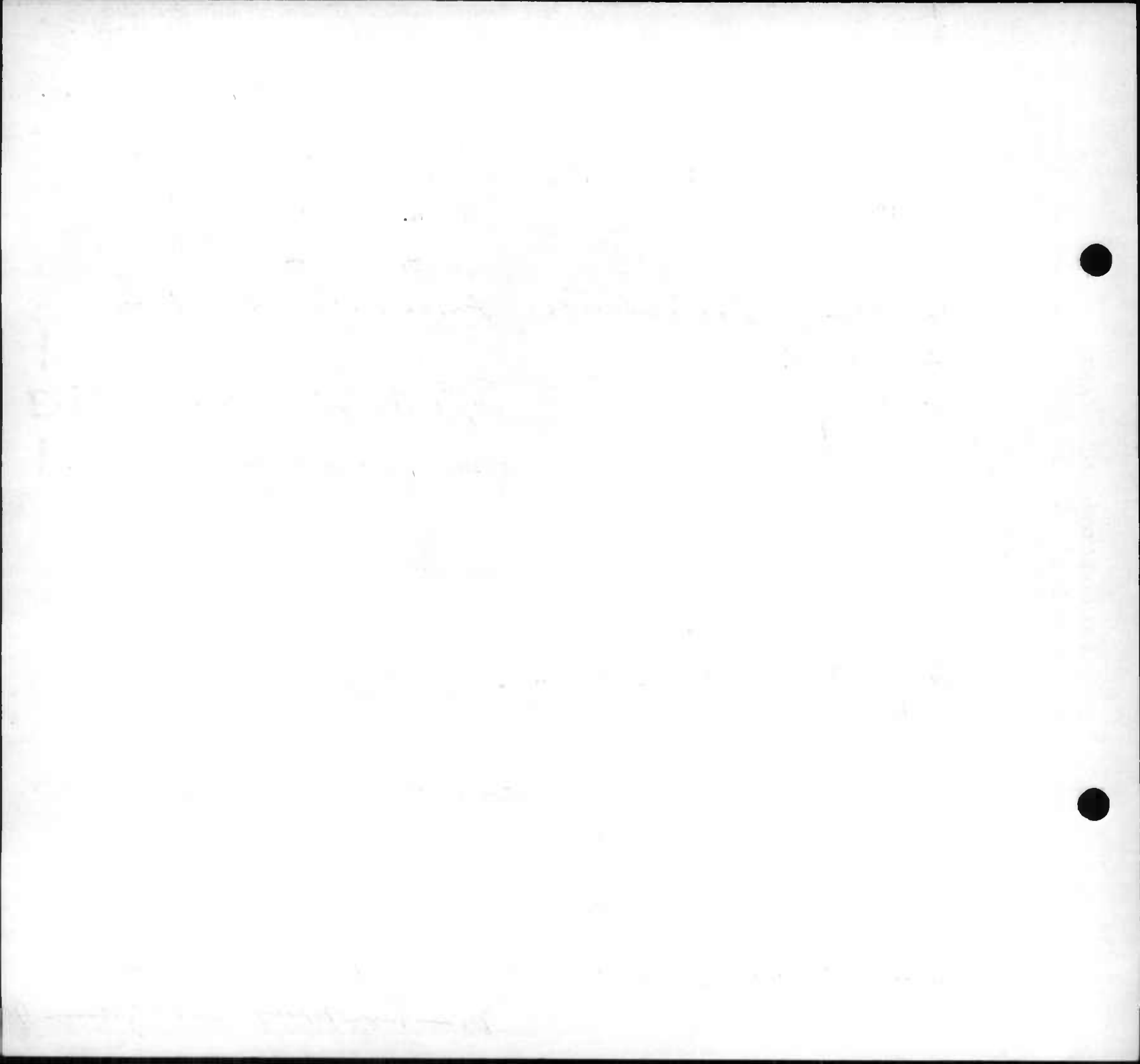




FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 11102</b>	
67 11102		BIRTH NO. <b>8-650</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>ODELL BROWN</b>		<b>NOVEMBER 19, 1967 1 a.m.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b> <b>33</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>16-03</b> D. STREET ADDRESS (If rural, give location) <b>616 N. MOUNT STREET</b>	
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>7-4-10</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>	9. AGE (In years last birthday) <b>57</b>
11. BIRTHPLACE (State or foreign country) <b>FAIRFOLD CO S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Andrew Brown</b>		14. MOTHER'S MAIDEN NAME <b>ELLA BROWN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Sydney Brown 616 N Mount St</b>		ADDRESS	
18. <b>156.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma, ? hepatic primary ? metastatic to liver</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>7/29/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Needle bx. liver -dx.</b>	
20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <b>this hospital</b> attended the deceased from <b>July 21, 1967</b> to <b>Nov. 19, 1967</b> , that (I) <b>we</b> last saw the deceased alive on <b>Nov. 19, 1967</b> and that in (my) <b>our</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>We</b> (did) (did not) view the body after death.			
23A. SIGNATURE <b>David J. Shaw</b>		23B. DATE SIGNED <b>11/19/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>DAVID J. SHAW</b>		23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL - CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>11/24/67</b>	
24C. NAME of CEMETERY or CREMATORY <b>West Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 20 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD</b>	
25C. FUNERAL DIRECTOR <b>Manhattan Funeral Home</b>		ADDRESS <b>635 N. Guilford St</b>	



BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED

(Type or Print)

RAYMOND

STOKES

2. DATE AND HOUR PRONOUNCED DEAD

November 18, 1967

6:00 P.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1008 Bennett Place

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1008 Bennett Place

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

Jan 9-1904

9. AGE (In years  
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

RET LONGBOROUGH

10B. KIND OF BUSINESS OR INDUSTRY

Bord 7 BACTO

11. BIRTHPLACE (State or foreign country)

CARROLL CO MD

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

ALBERT STOKES

14. MOTHER'S MAIDEN NAME

DELLA COPPAGE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

220-12-8234

17. INFORMANT

VIOLA SMITH 1335 HONESTAD ST

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDIION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDIIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

11/19/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

11/25/67

23C. NAME of CEMETERY or CREMATORY

Mt Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

NOV 20 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Manfred P. Hays 638 N Guilmon St

WILLIAM FORGE

1841-1842

1841

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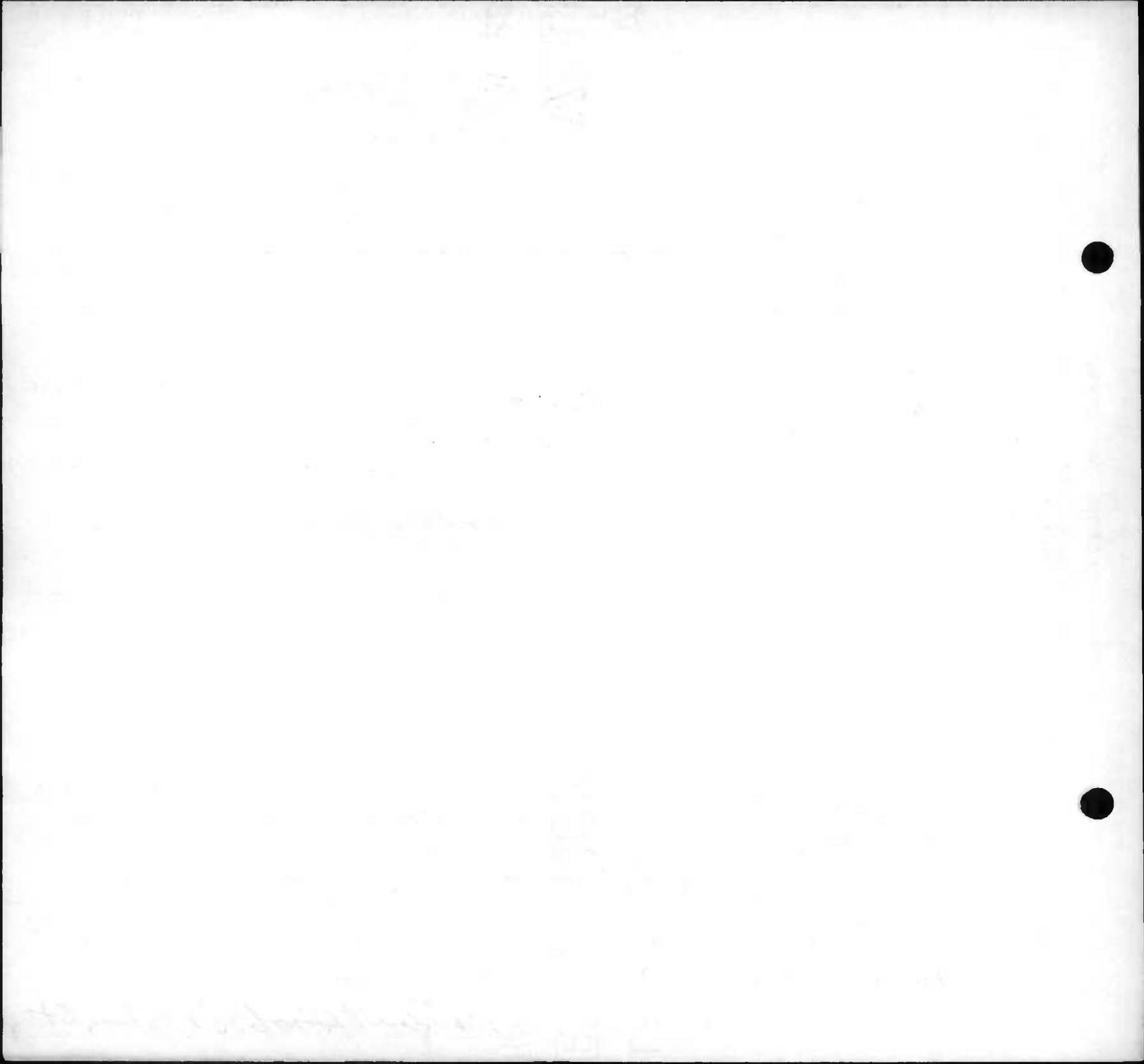
1849

1850

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-456		67 11104		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11104	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
WILMORE, MR. ROBERT F.				11-19-67 9:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
MONTEBELLO STATE HOSPITAL				MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				1923 W. FRANKLIN STREET			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
M	C	MARRIED	11-1-1910	57			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
FOREMAN		FOREMAN		BALTIMORE, MD		U.S.A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
WILLIAM WILMORE				MARRIE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				213-053256		BENLAH WILMORE (His wife)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CEREBRAL A. THROMBOSIS		4-3-1967	
ANTECEDENT CAUSES				(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO		A.S.C.V.D & H.C.V.D YEARS	
				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
D				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 6-19-1967 to 11-19-1967, that (I) (we) last saw the deceased alive on 11-19-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
ZIN U. PARK				11-19-67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
ZIN U. PARK		MONTEBELLO STATE HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		11/22/67		Mt Auburn		Baltimore	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 28 1967		Robert E. Fairbank		Franklin & Adams 6387		Gibson St	



J-525 67 11105		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11105	
M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
THELMA E. JOHNSON		November 18, 1967 4:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE Maryland	
St. Agnes Hospital		B. COUNTY Howard Co	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
		Jessups	
		D. STREET ADDRESS (If rural, give location)	
		Bx 267, Route 2, Wye Road	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
Female	Negro	Married	10-22-1929
9. AGE (In years last birthday)	38	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)
		Nursing Aide State Hosp.	A. A. Co. Md.
12. CITIZEN OF WHAT COUNTRY?	USA	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
		WOODRUFF MATTHEWS	HOLON GAITHER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	NO	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
			Charles Johnson - Jessups road
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
E816.4 I			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Multiple Injuries	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO	
ANTECEDENT CAUSES		(B) DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	21D. TIME OF INJURY (APPROX.)
	street	Montivedo Road	11/18/67 3:20 P. M.
21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	Driver in auto-auto	
WHILE AT WORK <input type="checkbox"/>	NOT WHILE AT WORK <input checked="" type="checkbox"/>	collision	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED	
Werner U. Spitz, M.D.		11/19/67	
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME OF CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Buried	11/22/67	Baltimore National	Baltimore Md
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	24D. ADDRESS
NOV 20 1967	Robert E. Fisher, M.D.	Marshall P. Hays	638 N. Guilford

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]*



J-525 67 11106

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 11106

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

CHARLES

G

JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

November 18, 1967

3:55 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)40  
91  
St. Agnes Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Jessups

D. STREET ADDRESS (If rural, give location)

Box 267, Rt. #2, Wye Road

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

6-19-1950

9. AGE (In years  
last birthday)

17

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired.)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Animal Farm

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

CHARLES JOHNSON

14. MOTHER'S MAIDEN NAME

Thelma Matthews

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

CHARLES JOHNSON - Jessup MD

18.

E 816.4

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Multiple Injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

D

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?U.S. Route 1 - 100 ft. north  
of Montivedo Road21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

11/18/67 3:20 P.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

collision.

Passenger in auto-auto

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/19/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/22/67

23C. NAME OF CEMETERY or CREMATORY

BALTO NATIONAL

23D. LOCATION

BALTO Ind

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 20 1967

24B. NAME OF REGISTRAR

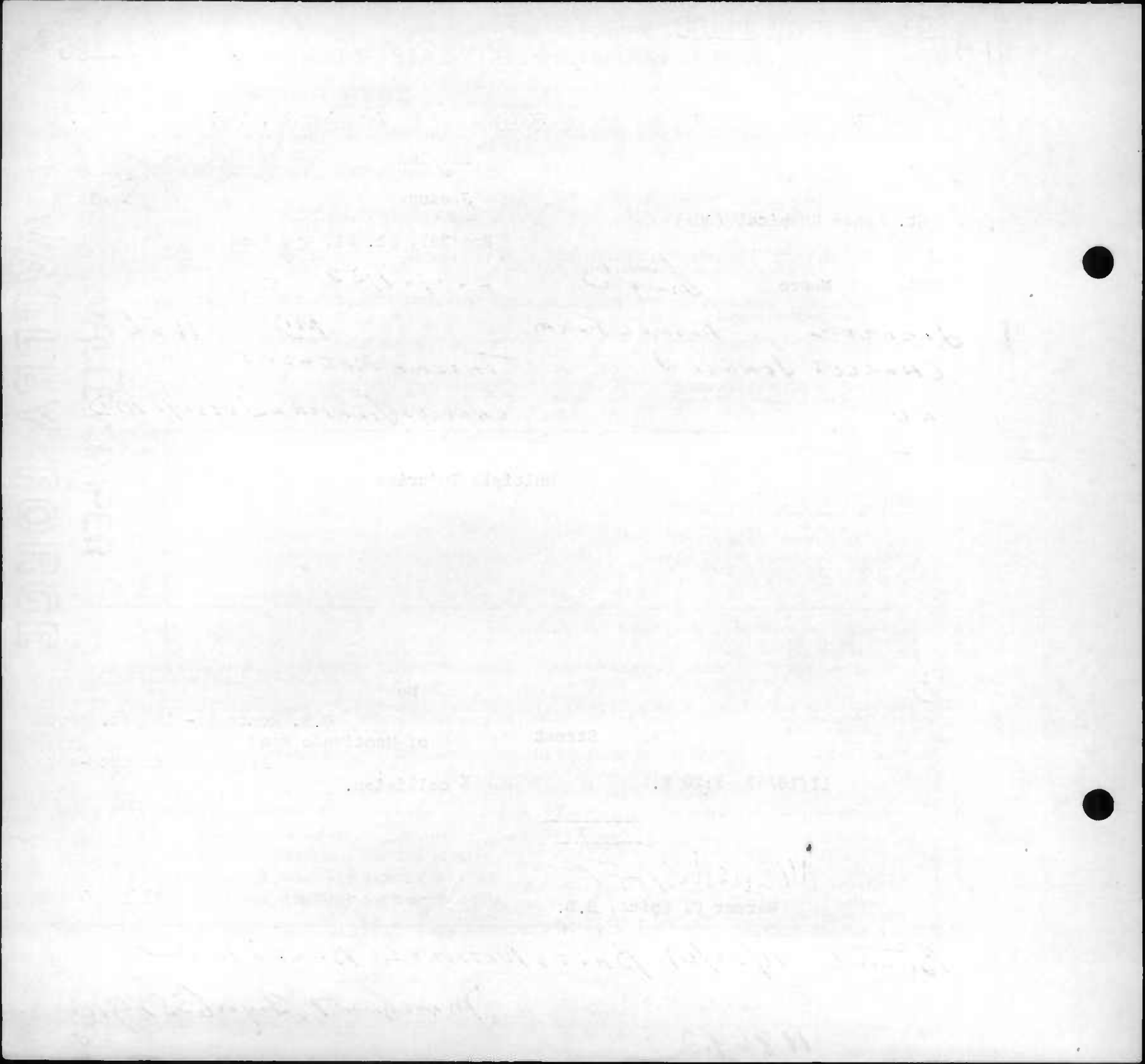
Robert E. Farkas

24C. FUNERAL DIRECTOR

Marion P. Hyatt

ADDRESS

638 9th Ave



H-350

67 11107

BALTIMORE CITY HEALTH DEPARTMENT

67 11107

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MARY

G.

HAYDEN

2. DATE AND HOUR PRONOUNCED DEAD

November 19, 1967

9:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

3722 Old York Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3722 Old York Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

12/25/1882

9. AGE (In years  
last birthday)

84

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Seamstress

10B. KIND OF BUSINESS OR INDUSTRY

Clothing Mfg. Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Hayden

14. MOTHER'S MAIDEN NAME

Ellen ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

yes

17. INFORMANT

ADDRESS

Mrs. Geraldine Boston 3722 Old York Rd

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/19/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/22/67

23C. NAME OF CEMETERY or CREMATORY

Baltimore Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

NOV 20 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Baltimore St

WALLLEY FORTGE  
SPECIAL AGENT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-342 67 11108		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11108	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
WILLIAM STYLES		2. DATE AND HOUR OF DEATH 11.18.67		11015 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		BALTIMORE		25-32	
D. STREET ADDRESS (If rural, give location)		1106 CHERRY HILL ROAD			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-10-15	9. AGE (In years last birthday) 52	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ANDREW		14. MOTHER'S MAIDEN NAME MARY KELLY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Evelyn Styles 1106 Cherry Hill Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 44381 + 002.1		CAUSE OF DEATH (A) DUE TO Multiple pulmonary emboli and anemia		INTERVAL BETWEEN ONSET AND DEATH 1 week	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) HASCDV		12+ years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Pulmonary tbc, treated		35 yrs.	
19A. DATE OF OPERATION 11.10.67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Nephrolithiasis		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 11-12 1967 to 11-18 1967, that (I) (we) last saw the deceased alive on 11-18 1967, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Christopher B. Merritt		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11.19.67	
23C. PHYSICIAN'S NAME (Type) Christopher B. Merritt		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/22/67		24C. NAME OF CEMETERY or CREMATORY Mt Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. NOV 20 1967		25B. NAME OF REGISTRAR Robert E. Finkbeiner	
25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. Barnes St			

11-10-11

11-10-11

Christopher & Morrell  
Christopher & Morrell

11-18

11-15

11-12

Received for  
pay

HASCD

Multiple business entities  
and more

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-630 67 11109		BALTIMORE CITY HEALTH DEPARTMENT		67 11109	
BIRTH NO.		<b>CERTIFICATE OF DEATH</b>		Registered No. 961	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print)			11/20/67 1:15 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Bolton Hill Nursing & Convalescent Ctr.,			Maryland		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			Baltimore		
D. STREET ADDRESS (If rural, give location)			605 N. Curley Street		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days Hours Min.
F	White	Widowed	1/7/77	90	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					U.S.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Joseph Kiper			Anna Frick		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		220-22-8203		Mrs. Catherine Heinle 605 N. Curley St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
331X4Y54X			Interval Between Onset and Death		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) cerebral vascular accident hours		
			(B) arteriosclerosis generalized years		
			(C) C.A. reaction - angina years		
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
7/67		Cerection - localized edema			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8/5 1967 to 11/20 1967, that (I) (we) last saw the deceased alive on 11/19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
ALLAN H. MACHT M.D.				11/20/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
ALLAN H. MACHT				2 EAST REAO ST 21202	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/24/67		Holy Redeemer Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 20 1967		Robert E. Farkas		John A. Moran, Inc. 3000 E. Baltimore St	

Page 10 of 10



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BIRTH NO. 67 11110		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11110	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HUGHES, IRENE			2. DATE AND HOUR OF DEATH NOVEMBER 11, 1967 10:35 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2-13-68 40 ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21207 D. STREET ADDRESS (If rural, give location) 5935 SUNSET AVENUE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12/25/18	9. AGE (In years last birthday) 49	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VA	
13. FATHER'S NAME WALTER SAMSON			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215 54 2478		17. INFORMANT ADDRESS ST AGNES' RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 171X I Severe Radiation Cystitis <del>Cancer Urinary Bladder</del> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Severe Debilitation secondary to Multiple Surgery and Hemorrhage Previous Diagnosis of Carcinoma of cervix, treated by Irradiation			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from AUGUST 9TH 1967 to NOVEMBER 11TH 1967, that (X) (we) last saw the deceased alive on NOVEMBER 11TH 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE <i>John H. G.</i> M.D.				23B. DATE SIGNED 11-13-67	
23C. PHYSICIAN'S NAME (Type) LABORDA Oscar				23D. ADDRESS M.D. CATON & WILKENS AVE BALTIMORE MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/19/67		24C. NAME OF CEMETERY OR CREMATORY WARD'S CHAPEL	
24D. LOCATION LIBERTY ROAD BALTO CO. MD		25A. DATE REC'D BY HEALTH DEPT. NOV 20 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Stansbury Funeral Home		25D. ADDRESS			

Letter from St. Agnes Hospital  
2-13-68 M.H.

ST. AGNES HOSPITAL

PHILADELPHIA, PA.

NEW YORK, N.Y.

ST. AGNES HOSPITAL

PHILADELPHIA, PA.

ST. AGNES HOSPITAL

PA.

ST. AGNES HOSPITAL

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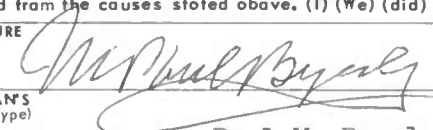
ST. AGNES HOSPITAL

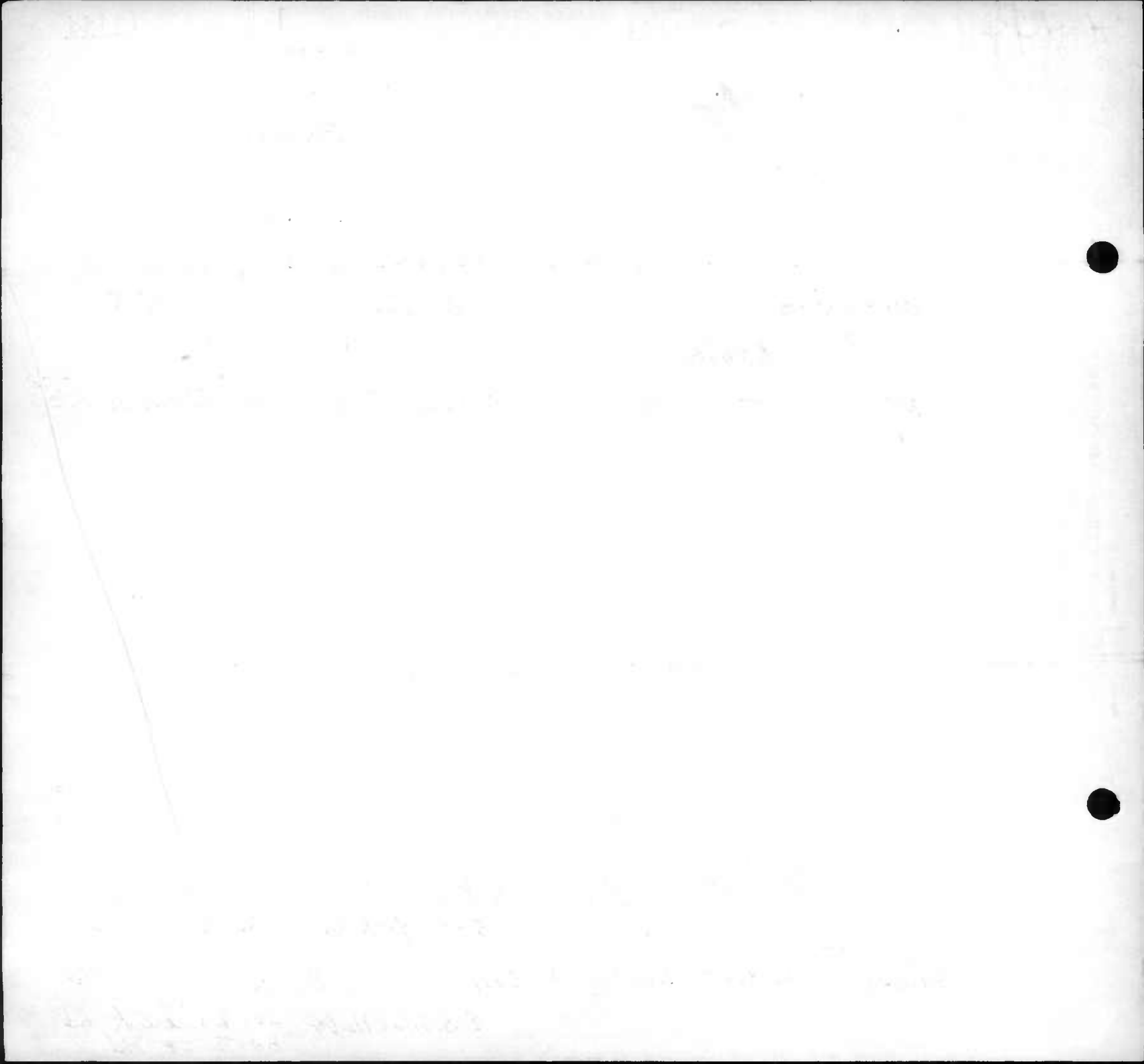
ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

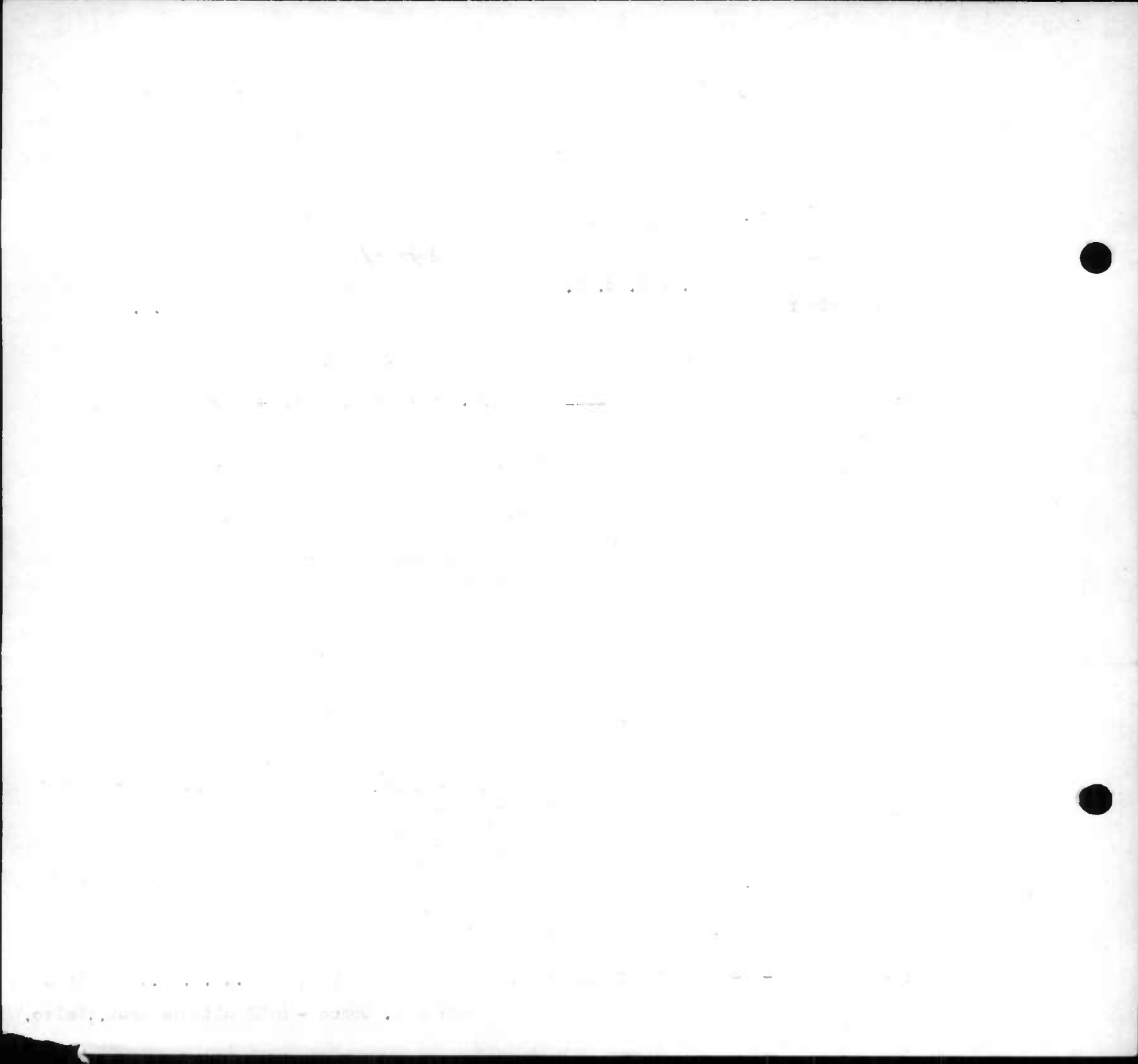
67 11111		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11111	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <div style="text-align: center;">Hall, Edna M.</div>			2. DATE AND HOUR OF DEATH November 16th, 1967   9:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <div style="text-align: center;">Saint Agnes Hospital 40 Caton &amp; Wilkens Aves. 2129</div>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland BALTO. Co C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00 D. STREET ADDRESS (If rural, give location) 1503 Idlewild Ave. 21228		
5. SEX F	6. RACE Cau	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/31/1893	9. AGE (In years lost birthday) 74	10. Under 1 Yr. Months: Days: (If Under 24 Hrs. Hours: Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. Va.	
13. FATHER'S NAME ? Kable			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT BURNARD J. HALL	
				ADDRESS #28 1503 Idlewild Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I CORONARY OCCLUSION			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Similarity between 5 and 16					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 16 1967 to Nov 16 1967, that (I) (we) last saw the deceased alive on Nov 16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED 11/17/67		
23C. PHYSICIAN'S NAME (Type) Paul M. Byerly			23D. ADDRESS 5820 York Rd BALTO Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/18/67		24C. NAME OF CEMETERY OR CREMATORY Loudon Pk. Cem.	
				24D. LOCATION (City, town, or county) (State) BALTO Md.	
25A. DATE RECEIVED BY HEALTH DEPT. NOV 20 1967		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR E.S. MacNabb	
				ADDRESS 301 Frederick Rd. BALTO 28 Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

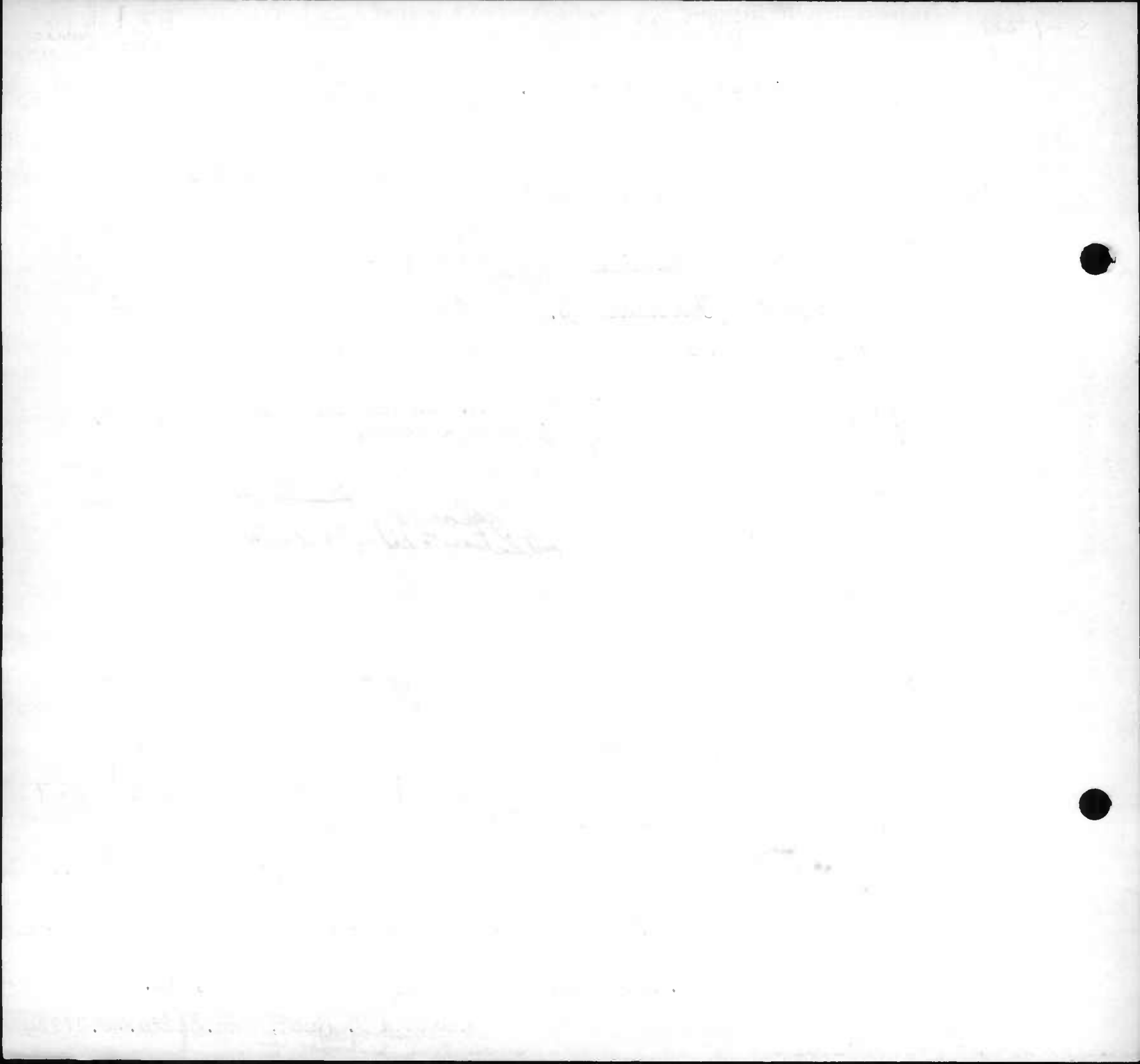
67 11112		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11112	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				COLEMAN, ELMER A.	
2. DATE AND HOUR OF DEATH		11-14-67 10:50 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland			
433 South Baltimore General Hosp.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #2/225			
5. SEX M		6. RACE W		D. STREET ADDRESS (If rural, give location) 4143 HYDEN CT.	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 9-24-01		9. AGE (In years lost birthday) 66	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Passer		10B. KIND OF BUSINESS OR INDUSTRY B. & O. R. R. Retired		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME William Coleman			
14. MOTHER'S MAIDEN NAME Martha Anderson		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. ----		17. INFORMANT ADDRESS Mrs. Anna Mae Coleman - same			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) MYOCARDIAL INFARCTION DUE TO (B) CONGESTIVE HEART FAILURE DUE TO (C) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (we) (this hospital) attended the deceased from 11-3-67 19 to 11-14 19 67, that (we) last saw the deceased alive on 11-14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gerard D. Dobrzucki, M.D.		23B. DATE SIGNED 11/15/67		23C. PHYSICIAN'S NAME (Type) Gerard P. Dobrzucki, Sr. M.D.	
23D. ADDRESS 1213 Light St.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 11-18-1967		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Ritchie Hwy., A.A.Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 20 1967		25B. NAME OF REGISTRAR Robert E. Jarboe, M.D.		25C. FUNERAL DIRECTOR ADDRESS George J. Gonce - 4001 Ritchie Hwy., Balto.	



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <b>67 11113</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>67 11113</b>	
1. NAME OF DECEASED (Type or Print) <b>SEEBACH, MARIE A.</b>			2. DATE AND HOUR OF DEATH <b>11/19/67 - 11:50 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>NORTH CHARLES GENERAL HOSP.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>21218</b> D. STREET ADDRESS (If rural, give location) <b>2718 Hugo Ave.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>2/23/05</b>	9. AGE (In years last birthday) <b>62</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BOOKKEEPER</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Furniture Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Md</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>CHARLES KREITLER</b>		
14. MOTHER'S MAIDEN NAME <b>AUGUSTA KOSSMAN</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>217-36-3088</b>			17. INFORMANT <b>Mr. Charles Seebach</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>163 X I</b> <b>Bronchopneumonia,</b> <b>SHOCK, HYPERCALCEMIA</b> <b>MALIGNANCY OF UNKNOWN ORIGIN</b> <b>metastasis to bone &amp; liver</b>			19. INTERVAL BETWEEN ONSET AND DEATH <b>10/13/67 - 11/19/67</b>		
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
22. DATE OF OPERATION <b>2</b>		23. CONDITION FOR WHICH OPERATION WAS PERFORMED		24. AUTOPSY? (Yes or No) <b>yes</b>	
25. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
28. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		29. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		30. HOW DID INJURY OCCUR?	
31. I certify that (I) (this hospital) attended the deceased from <b>10/13/1967</b> to <b>11/19/1967</b> , that (I) (we) last saw the deceased alive on <b>11/19/1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.					
32. SIGNATURE <b>Peter A. Papastamou</b>			33. DATE SIGNED <b>11/19/67</b>		
34. PHYSICIAN'S NAME (Type) <b>PETER A. PAPASTAMOU</b>			35. ADDRESS <b>NORTH CHARLES GENERAL HOSPITAL</b>		
36. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		37. DATE <b>11/22/67</b>		38. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	
39. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		40. STATE (State) <b>Md.</b>			
41. DATE REC'D BY HEALTH DEPT. <b>NOV 20 1967</b>		42. NAME OF REGISTRAR <b>Robert E. Taylor</b>		43. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>	

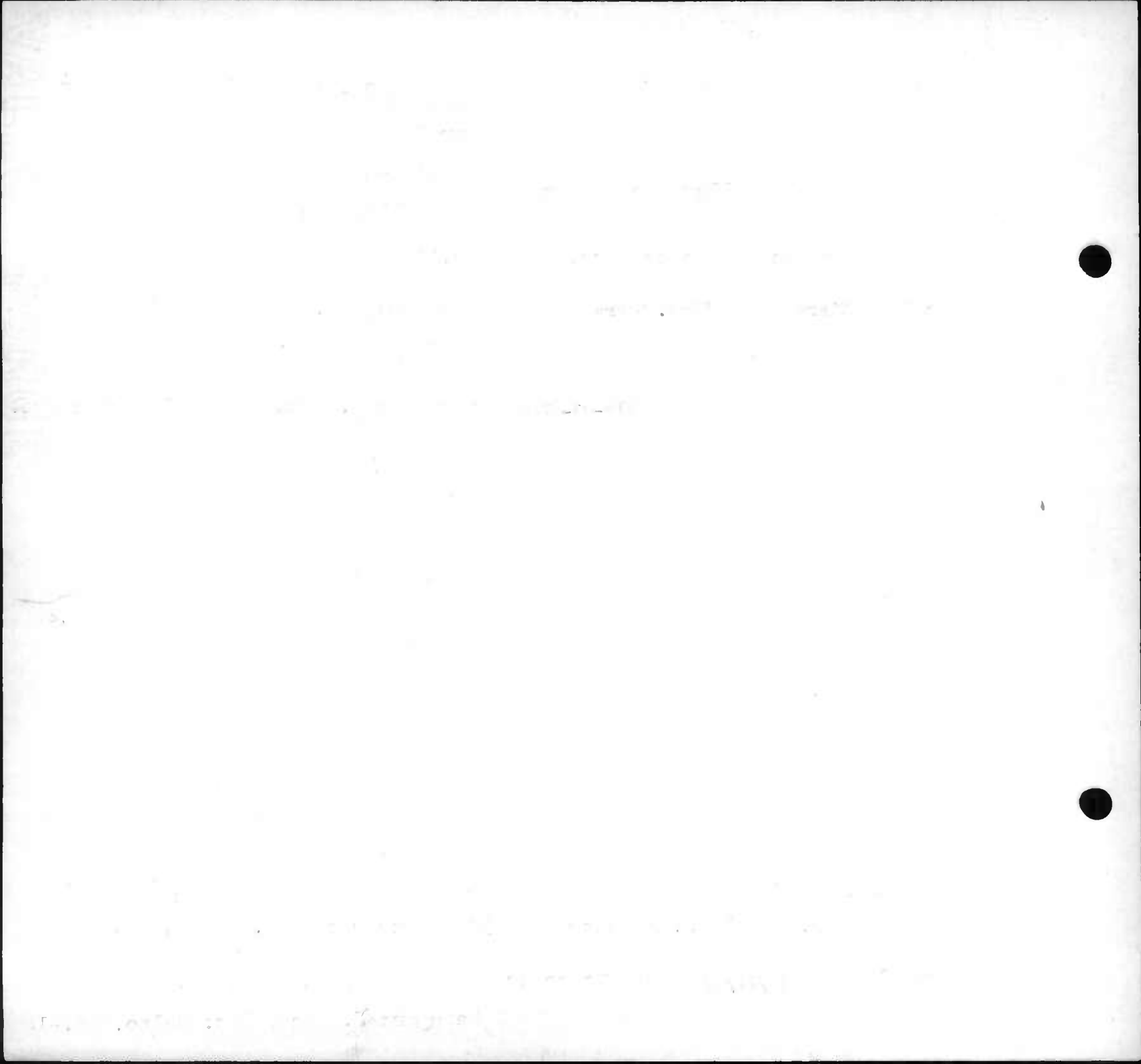




FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 11114</u>	
BIRTH NO. <u>67 11114</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>ANNIE E. LUTZ</u>		2. DATE AND HOUR OF DEATH <u>Nov. 20, 1967</u> <u>5:54</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <u>3300 Ellerslie Avenue</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>3300 Ellerslie Avenue</u>			
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>never married</u>	8. DATE OF BIRTH <u>Jan. 22, 1890</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>DEpt. Store</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ALBERT H. LUTZ</u>		14. MOTHER'S MAIDEN NAME <u>MARY M. MARKLEY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-03-8718</u>		17. INFORMANT ADDRESS <u>Miss Rose E. Lutz: 3300 Ellerslie Ave.</u>	
18. <u>443 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH <u>Arteriosclerotic Heart Disease</u> <u>acute congestive failure</u> <u>Hypertension C.R.</u> <u>Rheumatoid Arthritis</u> <u>Gen. Arteriosclerosis</u>			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/15</u> <u>1967</u> to <u>11/20</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>11/20</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Donald W. Mintzer</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>11/20/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Donald W. Mintzer</u>		23D. ADDRESS <u>3009 Evergreen Ave, Balto, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>11/22/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 20 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck, Inc: Balto, Md.-14</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 11115		<b>CERTIFICATE OF DEATH</b>		67 11115	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>Smith, Stella C.</u>			2. DATE AND HOUR OF DEATH <u>11/19/67 1:45 A.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hosp</u>			A. STATE <u>Md.</u> B. COUNTY <u>Balt City</u>		
(If not in hospital or institution, give street address, or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 21206 26-02</u>		
D. STREET ADDRESS (If rural, give location) <u>4227 Shamrock Ave</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>03/27/15</u>	9. AGE (In years last birthday) <u>52</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Benjamin Frisino</u>			14. MOTHER'S MAIDEN NAME <u>June Antoinette</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>218-14-7357</u>		17. INFORMANT <u>Daniel J. Smith Husband</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>422.11</u>			CAUSE OF DEATH (A) DUE TO <u>Heart failure &amp; stroke</u> (B) DUE TO <u>AS &amp; VD</u> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Same</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/18 1967</u> to <u>11/19 1967</u> , that (I) (we) last saw the deceased alive on <u>11/19 1967</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Barry J. Weckesser</u>				23B. DATE SIGNED <u>11/19/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>BARRY J. WECKESSER</u>				23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u> <u>Union Memorial Hosp</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/22/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 20 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>	

Union General  
Hosp

F W

Benjamin Franklin

Mr. Galt

Baltimore  
4557 Shamrock Ave

000000 52

June 1st 1964

husband

4529 VO

no

Benjamin Franklin  
000000

000000

Union General  
J. T. Galt

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11116		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11116	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>VERNAGO, Walter Joseph</b>			2. DATE AND HOUR OF DEATH <b>11/18/67 11:05 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Veteran Administration Hospital 73900 Loch Raven Boulevard Baltimore, Maryland 21218</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>7807 Old Harford Road</b>		
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>7/24/22</b>	9. AGE (In years last birthday) <b>45</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory Mechanic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Auto Sales</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Stanko Vernago</b>			14. MOTHER'S MAIDEN NAME <b>Rose Conrad</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 12/19/42 to 11/6/45</b>		16. SOCIAL SECURITY NO. <b>213-16-58-41</b>		17. INFORMANT ADDRESS <b>Hospital Records</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 Hours</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Atelectasis, Lung</b>			<b>34 Days</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Paraplegia</b>			<b>+ 6 Months</b>		
19A. DATE OF OPERATION <b>10-16-67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma, Lft Lung</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>X</b> (this hospital) attended the deceased from <b>September 19, 1967</b> to <b>November 18, 1967</b> , that <b>X</b> (we) lost saw the deceased alive on <b>November 18, 1967</b> and that in <b>our</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X)</b> (We) (did) <b>(X)</b> view the body after death.					
23A. SIGNATURE <b>Edward O. Hunt</b>				23B. DATE SIGNED <b>11-18-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>EDWARD O. HUNT</b>		23D. ADDRESS <b>3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/22/67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cem.</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		24E. STATE (State) <b>Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>11/20/67</b>	
25B. NAME OF REGISTRAR <b>Leonard J. Ruck, Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Balto. Md. 21214</b>			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 2		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11117	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ANTONIA (TINA) J. WALDHAUSER		11-17-67 5:10 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND		CITY OR TOWN (If outside city limits, write RURAL and give township)	
THE JOHNS HOPKINS HOSPITAL				BALTIMORE 21221	
		D. STREET ADDRESS (If rural, give location)		53-00	
106 POPLAR RD.					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
FEMALE	WHITE	MARRIED	09-01-1894	73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Ma ryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
CHARLES ROUBALL		ELEANORE Vopolecky		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		217-54-4152		Mrs. Rita M. Harris (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
		(A) Recurrent Pulmonary Embolism		3 days	
		(B) Thrombophlebitis		2-3 weeks	
		(C) Congestive Heart Failure		1-2 years	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
MEDICAL CERTIFICATION		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11/14/67 to 11/17/67 that (I) (we) last saw the deceased alive on 11/17/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
JOHN R. STONE, M.D.				11/17/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JOHN R. STONE, M. D. M.D.		THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/22/67		Holy Redeemer Cemetery	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 20 1967		Robert E. Fisher, M.D.		Leonard J. Ruck, Inc. Ba lto. Md. 21214	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11118

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

67 11118

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JOHN T. BATTERDEN, Jr.

2. DATE AND HOUR OF DEATH

November 18, 1967 | 9:55 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

44 UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE 21202

D. STREET ADDRESS (If rural, give location)

1010 ST PAUL ST.

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

NEVER MARRIED

8. DATE OF BIRTH

12-26-06

9. AGE (In years  
lost birthday)

60

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

MUTUAL CLERK

10B. KIND OF BUSINESS OR INDUSTRY

Race Tracks

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

JOHN BATTERDEN

14. MOTHER'S MAIDEN NAME

CATHERINE J. THOMPSON

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW 2

16. SOCIAL  
SECURITY NO.

218-01-2968

17. INFORMANT

ADDRESS

Miss M. Catherine Batterden, 3710 The Alameda

18. 581.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) Liver Failure

DUE TO

(B) Laennec CIRRHOSIS

DUE TO

(C) Aspiration pneumonia

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

M. J. McNeight

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

✓

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from October 9, 1967 to November 18, 1967, that (I) (we) last saw the deceased alive on November 18, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Miguel Sanchez-Palacios

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

November 18, 1967

23C. PHYSICIAN'S  
NAME (Type)

Miguel Sanchez-Palacios

M.D.

23D. ADDRESS UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

11/22/67

24C. NAME OF CEMETERY or CREMATORY

New Cathedral Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 20 1967

25B. NAME OF REGISTRAR

Leonard J. Ruck, Inc.

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

JOHN BATTERSEN

MARYLAND

BALTIMORE

1010 ST PAUL ST.

M W NEVER MARRIED 12-56-01 28

MARYLAND

MUTUAL CLERK

JOHN BATTERSEN CATHERINE J THOMPSON

liver failure

ALCOHOLIC CIRRHOSIS

November 18 63  
October 19 63  
November 12 63

November 1963  
X  
JOHN BATTERSEN

JOHN BATTERSEN  
MUTUAL CLERK

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-450

67 11119

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

67 11119

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

THOMAS PILONE

2. DATE AND HOUR OF DEATH

Nov 16 1967 6:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

2216 E LOMBARD ST.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md. BALTO.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

2520 E FAUETTE ST.

5. SEX

M.

6. RACE

W.

7. MARRIED, NEVER MARRIED (WIDOWED, DIVORCED (Specify))

WIDOWED

8. DATE OF BIRTH

FEB. 22-1904

9. AGE (In years last birthday)

63

10. Under 1 Yr. Months Days

11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SHOEMAKER

10B. KIND OF BUSINESS OR INDUSTRY

LEATHER GOODS. SHOES

11. BIRTHPLACE (State or foreign country)

ITALY

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

VINCENT PILONE

14. MOTHER'S MAIDEN NAME

CONCETTA CIAMPALIA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

219-32-1283

17. INFORMANT

THOMAS PILONE JR. - 2216 E LOMBARD ST.

ADDRESS

18. 420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO

(B) DUE TO

(C) DUE TO

myocardial infarction

arterial scler heart disease 10 months previous infarction

cardiac decompensation 10 months

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

D

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

.

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (the hospital) attended the deceased from Feb 3 1967 to Nov 7, 1967, that (I) (we) last saw the deceased alive on Nov 7, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Joseph D. Antonio

M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

11/20/67

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

M.D.

100 N Broadway, Balto

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

11/20/67

24C. NAME OF CEMETERY or CREMATORY

HOLY REDEEMER

24D. LOCATION

BALTO. MD.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 20 1967

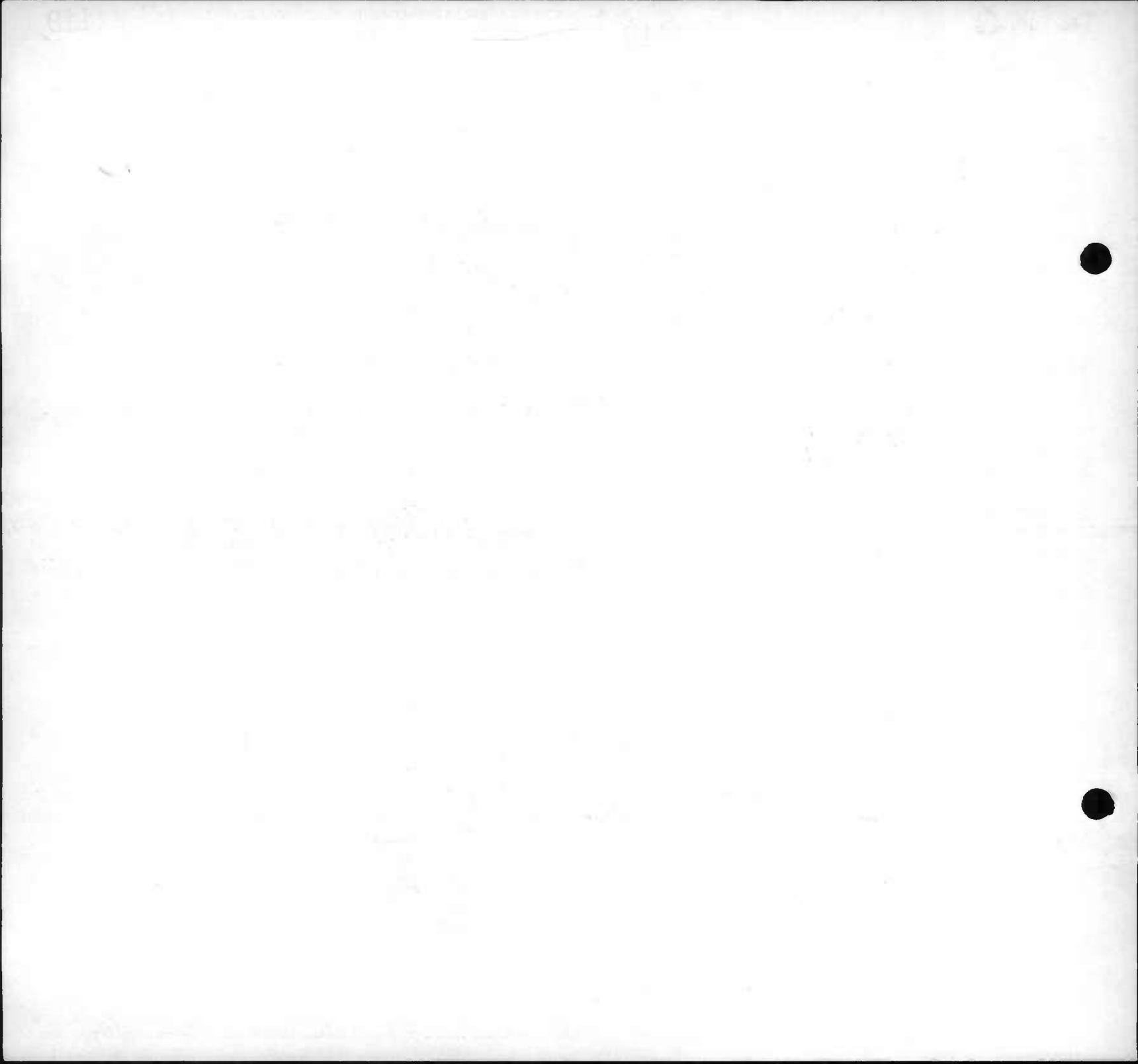
25B. NAME OF REGISTRAR

Ed E. Johnson

25C. FUNERAL DIRECTOR

Frank Della Noe 3225 High St.

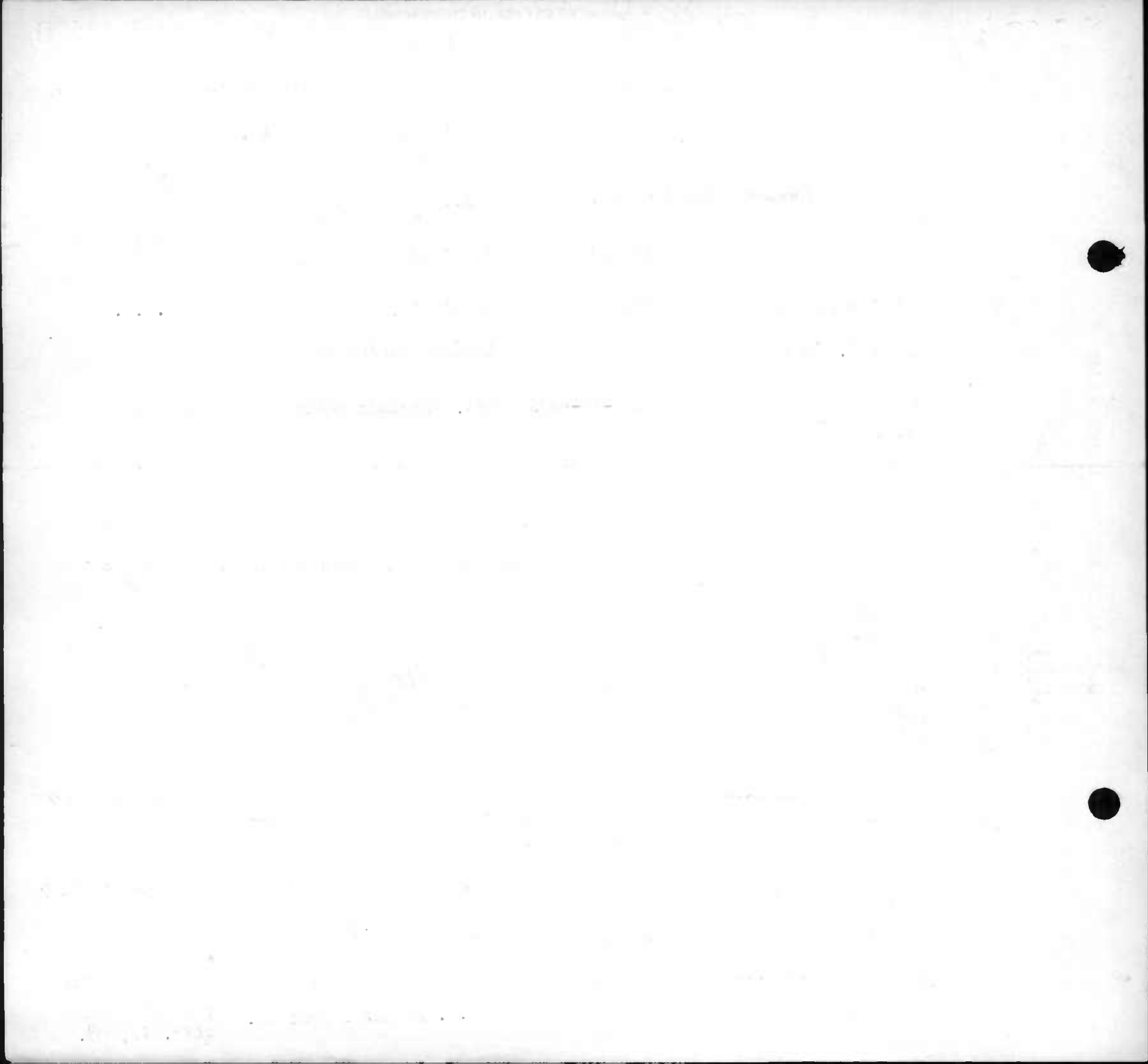
ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

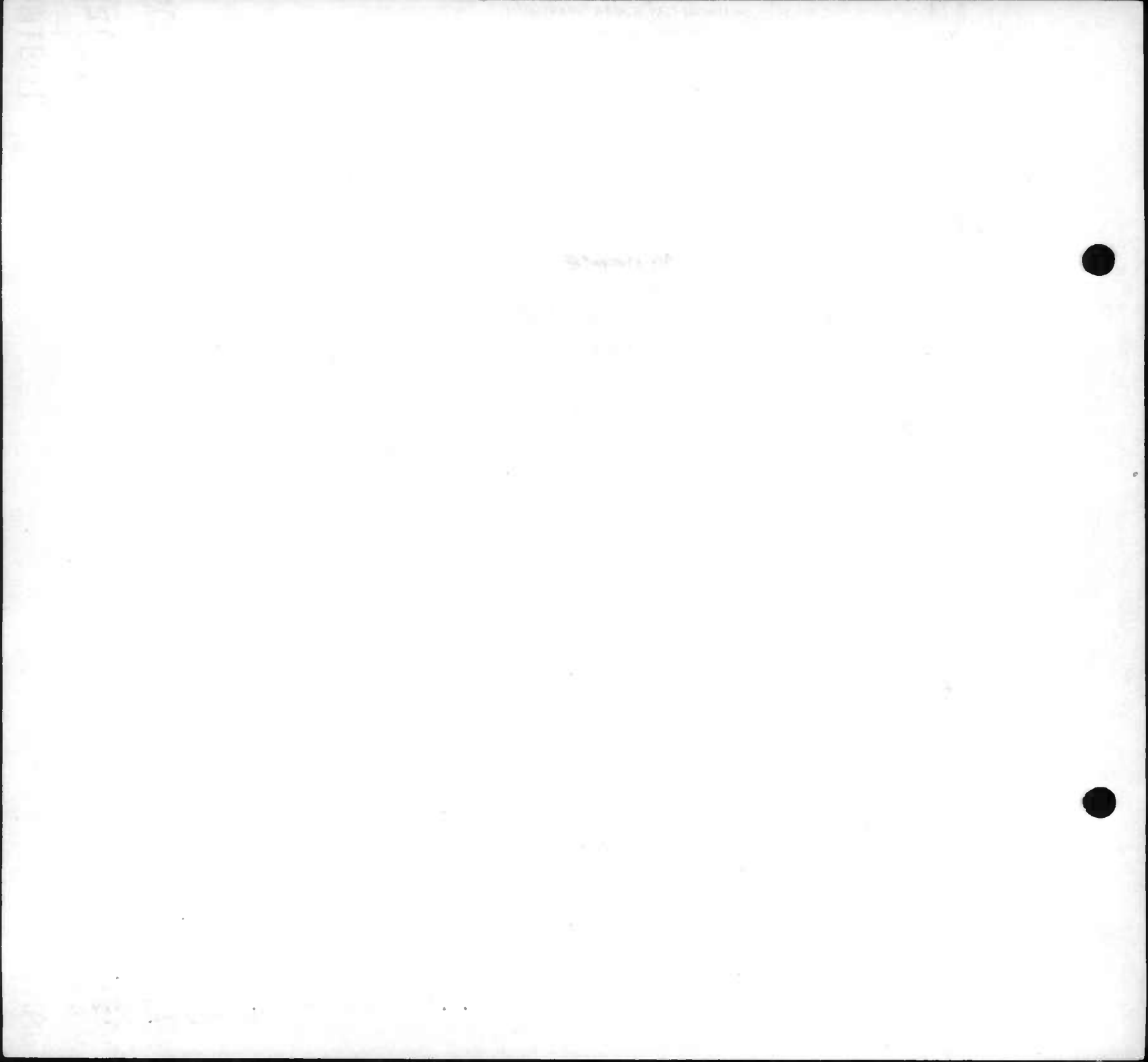
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11120		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. <u>X</u> 67 11120	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Lillie Depkin Grosche</i>			2. DATE AND HOUR OF DEATH <i>Mar. 18 1967</i>   <i>11:30 A. M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 Edgewood Nursing Home</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Balto.</i> C. CITY OR TOWN (If outside city limits, with RURAL and give township) <i>Towson</i> D. STREET ADDRESS (If rural, give location) <i>53-00</i> <i>711 Morningside Drive</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>8/24/1884</i>	9. AGE (In years last birthday) <i>83</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Never employed</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Louis F. Depkin</i>			14. MOTHER'S MAIDEN NAME <i>Louisa Gohling Horst</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-46-6406</i>	17. INFORMANT <i>Mrs. Dorathea White</i>		ADDRESS <i>(Same)</i>
18. <i>420.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <i>Emaciation</i> DUE TO (B) <i>Abdominal angina?</i> DUE TO (C) <i>Generalized arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12yr-</i> <i>12yr.</i> <i>5-yr+</i>
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>Oct 31 1967</i> to <i>Mar 18 1967</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>Mar 18 1967</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did</del> ) ( <del>not</del> ) view the body after death.					
23A. SIGNATURE <i>Frederick J. Vollmer</i>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>Mar 18, 1967</i>
23C. PHYSICIAN'S NAME (Type) <i>FREDERICK J. VOLLMER</i>			23D. ADDRESS <i>6100 York Rd</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/21/1967</i>	24C. NAME of CEMETERY or CREMATORY <i>Loudon Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 20 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>H.W. Jenkins &amp; Sons Co.</i> ADDRESS <i>4905 York Road Balto. 12, Md.</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

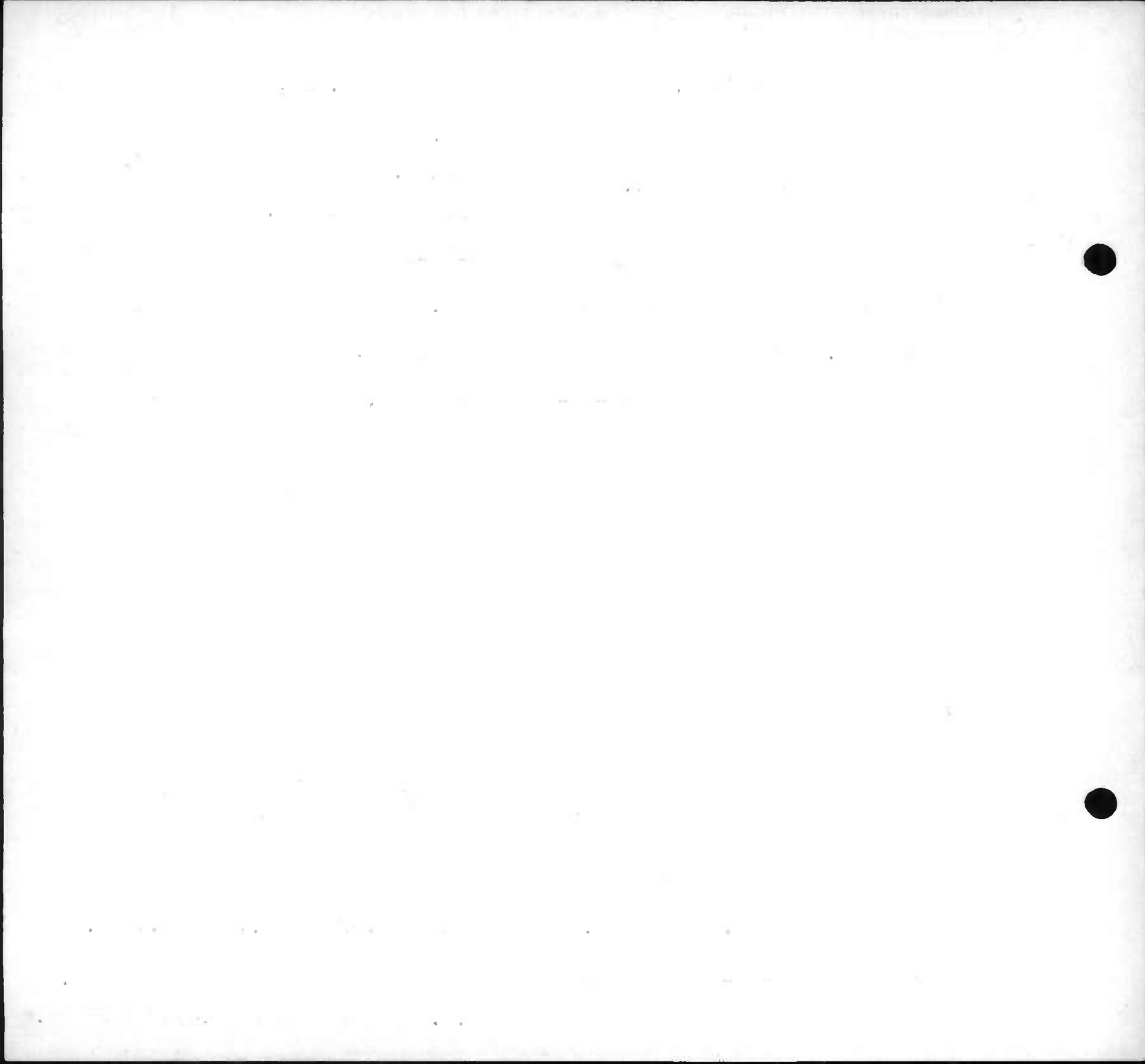
67 11121		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11121	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>MARGARET Waters, Mrs. Agnes</i>	
2. DATE AND HOUR OF DEATH <i>1-18-67</i>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hospital 48</i>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
D. STREET ADDRESS (If rural, give location) <i>3200 Woodholme Ave 21234</i>		5. SEX <i>Female</i>			
6. RACE <i>Caucasian</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i>		8. DATE OF BIRTH <i>12-12-99</i>	
9. AGE (In years last birthday) <i>67</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CASHIER-CAFETERIA</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Wm. Fletcher</i>		14. MOTHER'S MAIDEN NAME <i>Unknown KATHERINE</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-07-3358</i>		17. INFORMANT <i>admission sheet / granddaughter</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Glioblastoma Brain</i> (B) (C)  INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>11-17</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Brain tumor</i>		20A. AUTOPSY? (Yes or No) <i>No.</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>10-30</i> 19 <i>67</i> to <i>11-18</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>11-18</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Nabil F. Warsal</i> M.D.				23B. DATE SIGNED <i>11-18-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>NABIL F. WARSAL M.D.</i>				23D. ADDRESS <i>MARYLAND GENERAL Hosp</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/22/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 20 1967</i>			
25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR ADDRESS <i>H.W. Jenkins &amp; Sons Co. 4905 York Road Baltimore, Md. 21212</i>			





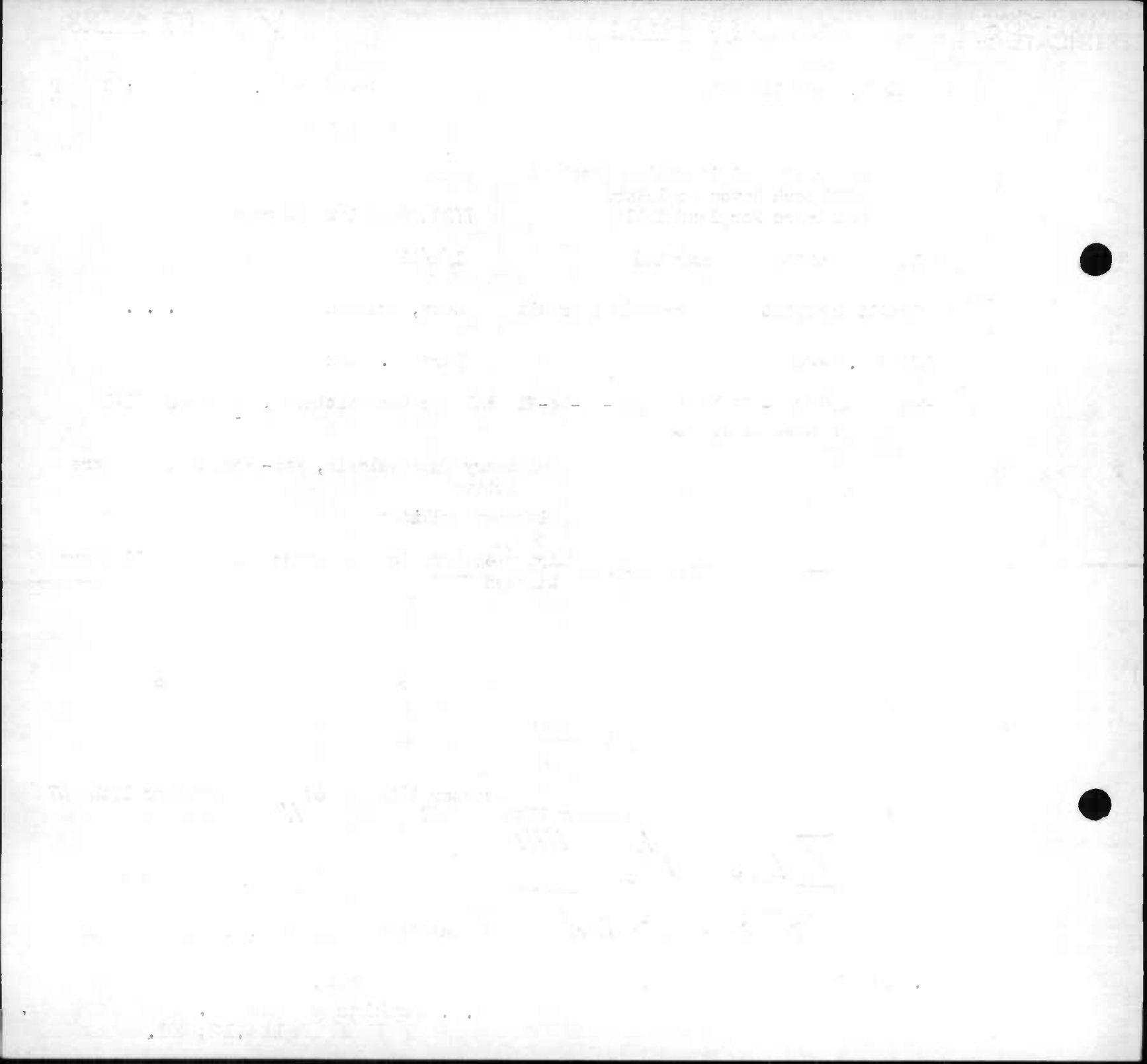
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 11122		67 11122		67 11122	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)			
		Nannie E. Dorsey			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		2. DATE AND HOUR OF DEATH			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Nov. 19, 1967 8 45 A M.			
00 3929 Keswick Rd.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto.			
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Buyer		Stationary		1-19-1882	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
Frank G. Dorsey		Nellie R.		85	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)	
No		215-07-0860		Md.	
17. INFORMANT		ADDRESS		12. CITIZEN OF WHAT COUNTRY?	
Charles W. Hancock		Above		USA	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422.11		Arteriosclerotic cardio vascular disease.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-16 19 59 to 11-19 19 67, that (I) (we) last saw the deceased alive on 11-13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Alfred G. Ossman Jr.		11-20-67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Alfred G. Ossman Jr.		1101 St. Paul St., Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Cremation		11-20-67		Greenmount	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 20 1967		Robert E. Finkbeiner		H.W. Jenkins & Sons Co. 4905 York Rd.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11123</b>	
BIRTH NO. <b>67 11123</b>				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>WADE, Roderick Paul</b>				<b>November 17, 1967 1:10 P M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>27 Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore Maryland 21218</b>				A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Towson</b>	
				D. STREET ADDRESS (If rural, give location) <b>7720 Greenview Terrace</b>	
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>1/4/91</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Credit Analyst</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Commerical Credit</b>		11. BIRTHPLACE (State or foreign country) <b>Howe, Indiana</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Alfred A. Wade</b>		
14. MOTHER'S MAIDEN NAME <b>Sarah E. Hawk</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 6/4/18 - 12/29/18</b>		
16. SOCIAL SECURITY NO. <b>216-03-88-71</b>			17. INFORMANT ADDRESS <b>VAH Records Baltimore, Maryland 21218</b>		
18. CAUSE OF DEATH <b>002.14+260 X</b>				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Tuberculosis, Far-Advanced, 30 years</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Active</b>					
(A) <b>Diabetes Mellitus</b>				<b>years</b>	
(B) <b>Arteriosclerotic Cardiovascular Disease</b>				<b>11 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <b>X</b> (this hospital) attended the deceased from <b>October 18th 1967</b> to <b>November 17th 1967</b> , that <b>(X)</b> (we) lost saw the deceased alive on <b>November 17th 1967</b> and that in <b>(X)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X)</b> (We) (did) <b>(X)</b> view the body after death.					
23A. SIGNATURE <b>Zaheer ud Din</b>				23B. DATE SIGNED <b>11/17/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>ZAHEER-UD-DIN</b>				23D. ADDRESS <b>VA Hospital Baltimore, Maryland 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Rem. Burial</b>		24B. DATE <b>11/21/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Riverside</b>	
24D. LOCATION <b>Howe, Indiana</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 20 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farkas</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>			



FUNERAL DIRECTOR: IMPORTANT

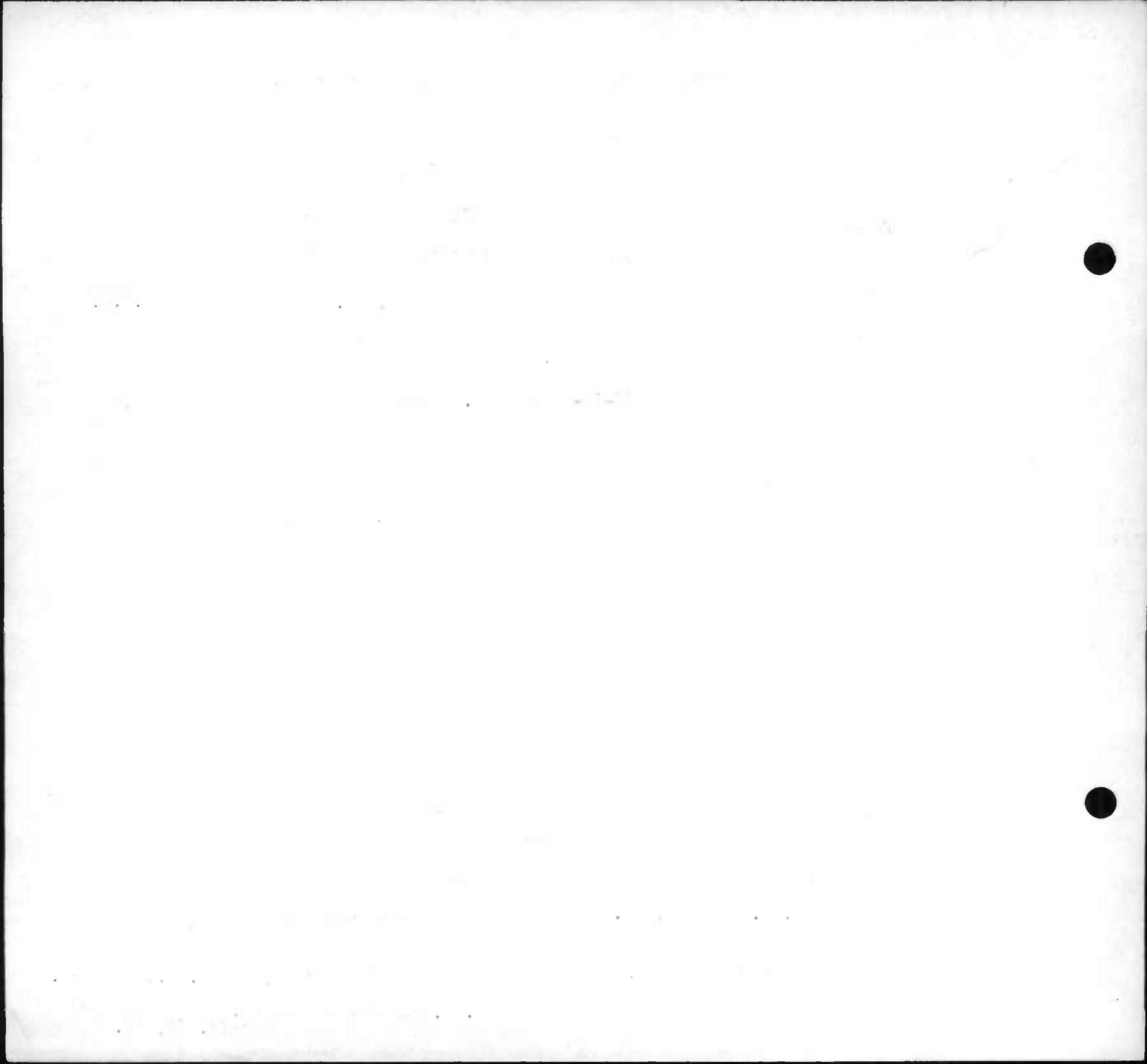
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11124		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11124	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Charles A. Bechtold		November 19, 1967 2:45 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland			
Union Memorial Hospital 44 Baltimore 18 Md		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore 27-14	
D. STREET ADDRESS (If rural, give location)		4401 Roland Ave			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days
M	W	Married	10-5-98	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED - POSTMASTER - FT. MEADE				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
August Wm Bechtold		Bessie Burkhardt		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes W W I		216-34-4300		Union Memorial Hospital	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Myocardial infarction		6 days	
ANTECEDENT CAUSES		(B) Coronary thrombosis		6 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Atherosclerotic Cardiovascular disease		sev. years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 1965 to Nov 19 1967, that (I) (we) last saw the deceased alive on Nov 19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Alfred G. Ossman, Jr.		11-19-67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Alfred G. Ossman Jr		1101 ST. PAUL ST. BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/22/67		Loudon Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 20 1967		Robert E. Jenkins		H.W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
1. NAME OF DECEASED (Type or Print)		Betty Straus Reeder		2. DATE AND HOUR OF DEATH November 15, 1967 1:45 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland			
5722 Kenmore Road		B. COUNTY			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore			
D. STREET ADDRESS (If rural, give location)		5722 Kenmore Road			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/31/1900	9. AGE (In years last birthday) 67	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Henry William Straus		14. MOTHER'S MAIDEN NAME Blanch Kraus		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-18-2821		17. INFORMANT T. Leonard Reeder	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) 420.1 I Acute Coronary Occlusion		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 15 min	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ARTERIOSCLEROTIC Cardiovascular Disease		7 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JANUARY 1964 to NOVEMBER 15, 1967, that (I) (we) last saw the deceased alive on November 1, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. J. Venable, Jr.		M.D.		23B. DATE SIGNED NOVEMBER 16, 1967	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 7215 York Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/18/67		24C. NAME OF CEMETERY or CREMATORY Druid Ridge	
24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 20 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.	





1  
C-636

67 11126

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 11126

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

VANCE E. CARTER

2. DATE AND HOUR PRONOUNCED DEAD

November 17, 1967 5:55 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 105 N. Stricker St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

105 N. Stricker St.

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

March 27, 1908

9. AGE (In years  
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Truck driver

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Carter

14. MOTHER'S MAIDEN NAME

Priscilla ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

22922-0512

17. INFORMANT

Elizabeth Jackson 1721 N. Azimuth St.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Tuberculosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No (Partial)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

Edward F. Wilson

M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

November 17, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/20/1967

23C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cem.

23D. LOCATION

Cedar Hill Md.

(City, town or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 20 1967

24B. NAME OF REGISTRAR

Robert E. Fawcett

24C. FUNERAL DIRECTOR

Williams Funeral Home 319 N. Schrader St.

ADDRESS

Truck driver  
John Carter  
No. 8  
Placed  
March 1900  
Frisco  
Mr. [illegible]  
[illegible]

Received  
of [illegible]  
[illegible]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-422		67 11127		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11127	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>WALTER FOWLKES</b>				2. DATE AND HOUR OF DEATH <b>20 NOVEMBER 1967 7:05 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI HOSPITAL OF BALTIMORE</b>				A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
D. STREET ADDRESS (If rural, give location) <b>3321 Dorfield Ave</b>				15-11			
5. SEX <b>Male</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>10/2/09</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Greensboro, N.C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Yusef Fowlkes</b>				14. MOTHER'S MAIDEN NAME <b>Nannie Fowlkes</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Ruth Fowlkes</b>		ADDRESS <b>3321</b>	
18. <b>237X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Intestinal Tumor of undet. type</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (the) (this hospital) attended the deceased from <b>11/13</b> 19 <b>67</b> to <b>11/20</b> 19 <b>67</b> , that (I) last saw the deceased alive on <b>11/19</b> 19 <b>67</b> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Abe Levy</b>				M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/20/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>ABE LEVY</b>				23D. ADDRESS <b>Sinai Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Nov 24/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus New York Arbutus</b>		24D. LOCATION (City, town, or county) (State) <b>MD 1129</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 21 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Zora P. Elickson</b>		ADDRESS <b>N. E. Blvd.</b>	

2nd Lt. William E. B. B. B.

10/2/52 28

Strategic Plan  
of the Army

10/2/52 28

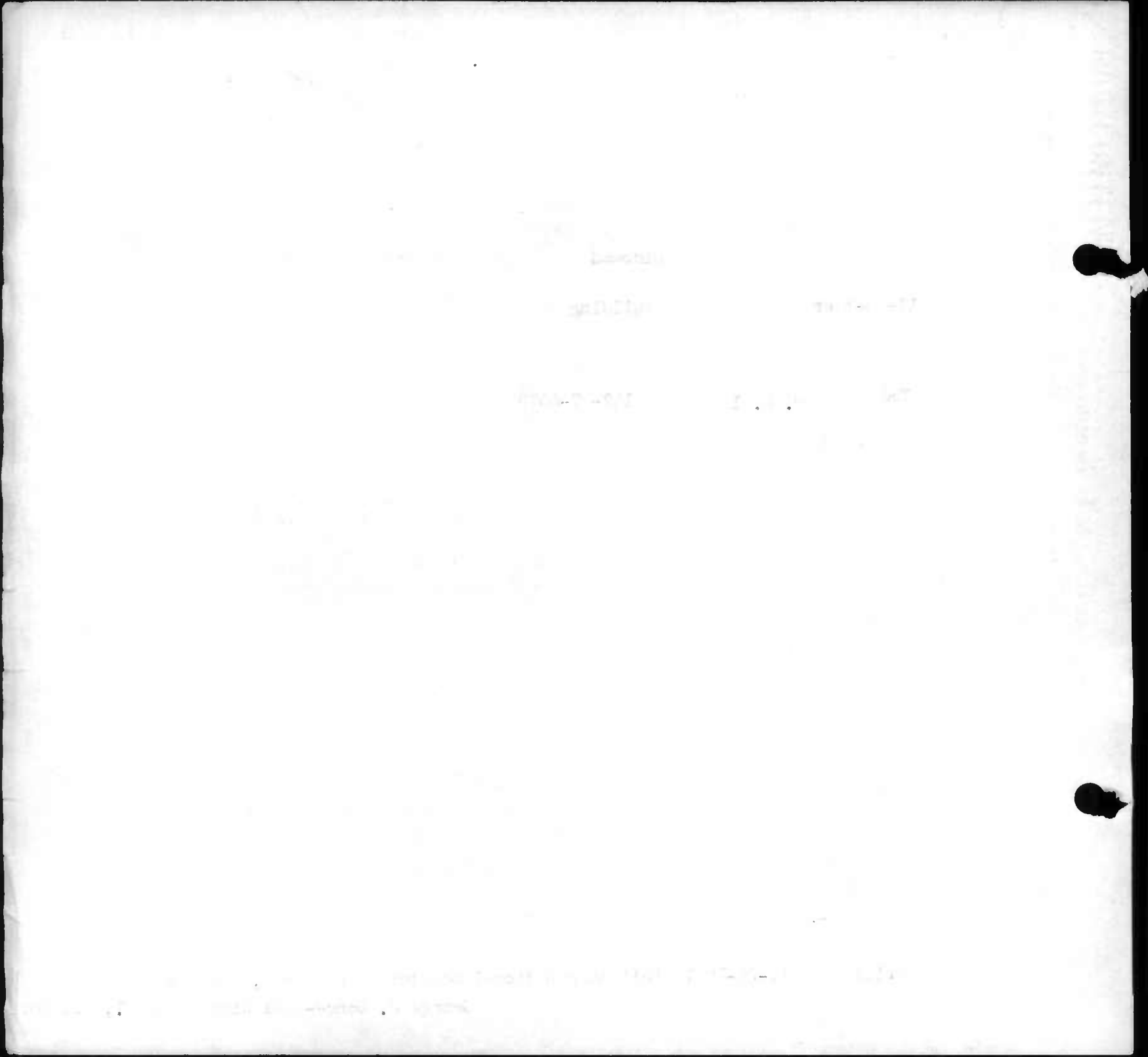
10/2/52 28

10/2/52 28

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 11128</u>	
67 11128				CERTIFICATE OF DEATH	
BIRTH NO. M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>WILLIAM H. HAYS</u>		2. DATE AND HOUR OF DEATH <u>NOV. 16, 1967</u> <u>6:05 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>36 FRANKLIN SQUARE HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>CLAY</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE 26</u> <u>52-00</u> D. STREET ADDRESS (If rural, give location) <u>6408 ARUNDEL COVE AVE.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>6-9-96</u>	9. AGE (In years last birthday) <u>71</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tile Setter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>W. W. 1</u>		16. SOCIAL SECURITY NO. <u>142-07-6079</u>		17. INFORMANT ADDRESS <u>FRANKLIN SQUARE HOSPITAL</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Massive myocardial infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>coronary arteriosclerosis</u>			CAUSE OF DEATH (A) <u>Massive myocardial infarction</u> DUE TO (B) <u>coronary arteriosclerosis</u> DUE TO (C) _____		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>II</u>			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>X</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>October 28</u> 19 <u>67</u> to <u>November 16</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>November 16</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ruben V. Lunde</u> M.D.				23B. DATE SIGNED <u>11-16-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>RUBEN V. LUNDE</u>				23D. ADDRESS <u>FRANKLIN SQUARE HOSPITAL</u> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-20-1967</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 21 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		25C. FUNERAL DIRECTOR ADDRESS <u>George J. Gonce-4001 Ritchie Hgwy1, Baltimore</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
67 11129				67 11129	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO.</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <b>Claude Green</b></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <b>19 November 1967</b> <b>4:37 p</b> M.</p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p><b>South Baltimore General Hospital</b></p>			<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</p> <p>A. STATE <b>Maryland</b> B. COUNTY <b>-</b></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b></p> <p>D. STREET ADDRESS (If rural, give location) <b>1520 W. Pratt St.</b></p>		
5. SEX <b>M</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>3/11/97</b>	9. AGE (In years, lost birthday) <b>70</b>	<p>If Under 1 Yr. Months: Days: Hours: Min.</p> <p>If Under 24 Hrs. Hours: Min.</p>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel worker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Steel Ind.</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
13. FATHER'S NAME <b>William Green</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No No</b>			16. SOCIAL SECURITY NO. <b>213 07 5460</b>		17. INFORMANT <b>wife</b>
18. <b>260 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Uremia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO <b>Diabetes Mellitis</b>		
			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>ASCVD, CHF</b>					
19A. DATE OF OPERATION <b>none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>3 November 1967</b> to <b>19 November 1967</b> , that (1) (he) last saw the deceased alive on <b>19 November 1967</b> and that in (my) ( ) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) ( ) view the body after death.					
23A. SIGNATURE <i>Ira L. Fetterhoff</i>				23B. DATE SIGNED <b>19 November 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ira L. Fetterhoff</b>		23D. ADDRESS <b>South Baltimore General Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-22-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Cross Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Co. Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 21 1967</b>		25B. NAME OF REGISTRAR <i>Robert E. Fairbanks</i>		25C. FUNERAL DIRECTOR <b>Walters Funeral Home Pratt &amp; Stricker</b>	

Handwritten signature or initials, possibly "H. H. H. H."



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 11130	
67 11130 CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		PEARL LORETTA CLA BAUGH		11-18-67 2:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
36 FRANKLIN SQUARE HOSPITAL		MARYLAND BALTIMORE COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		CATONSVILLE 53-00			
		D. STREET ADDRESS (If rural, give location)			
		6621 FREDERICK ROAD			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
F	W		8/15/98	69	Housewife
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
MARYLAND			USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JAMES WARFIELD			ELIZABETH MATTHEWS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			26-32 9381		
17. INFORMANT			ADDRESS		
FRANKLIN SQUARE HOSPITAL					
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 10-24-67 to November 18, 1967, that (I) (we) last saw the deceased alive on November 18, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Ruben V. Luna				11-18-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
RUBEN V. LUNA				FRANKLIN SQUARE HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		11/21/67		BALTIMORE NATIONAL CEM.	
				BALTO MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 21 1967		R. E. Farley		E. S. MacNabb	
				301 Frederick Rd	
				BALTO MD	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <b>67 11131</b>
BIRTH NO. <b>67-23260 67 11131</b>										<b>CERTIFICATE OF DEATH</b>
M.E. CASE NO.										
1. NAME OF DECEASED (Type or Print) <b>BABY BOY ARNDT</b>					2. DATE AND HOUR OF DEATH <b>11/18/67 1:00 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 21207 53-00</b>					
					D. STREET ADDRESS (If rural, give location) <b>2801 N. ROLLING RD.</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify) SINGLE</b>		8. DATE OF BIRTH <b>11/18/67</b>	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		
						12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>WILLIAM ARNDT</b>					14. MOTHER'S MAIDEN NAME <b>LONA RHYNARD</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO.		17. INFORMANT <b>ST. AGNES RECORDS-WILKENS &amp; CATON AVE.</b>			
18. <b>754.5 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) DUE TO <b>Coronary Heart Disease, Genetic type</b> (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that <del>XX</del> (this hospital) attended the deceased from <b>11/18/67</b> to <b>11/18/1967</b> that <del>XX</del> (we) lost saw the deceased alive on <b>11/18/67</b> and that in <del>XX</del> (our) opinion death occurred on the date and hour and from the causes stated above <del>XX</del> (We) (did) <del>(XXXX)</del> view the body after death.										
23A. SIGNATURE <i>R. O. Guzman</i>					M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>11/19/67</b>		
23C. PHYSICIAN'S NAME (Type) <b>R. O. GUZMAN</b>					23D. ADDRESS <b>St. Agnes Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)				
<b>11/20/67 BURIAL</b>		<b>BURIAL</b>		<b>Salem Lutheran</b>		<b>Catonville Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 21 1967</b>			25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>			25C. FUNERAL DIRECTOR <b>Paul E. Blumowicz, Jr.</b>			ADDRESS <b>3615 Chestnut Ave</b>	

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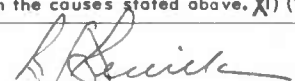
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11132		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 67 11132	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>SCHUCK, FRANK</b>		2. DATE AND HOUR OF DEATH <b>NOV. 19, 1967 4:35 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>21227</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVE. BALTIMORE, MD 21229</b>		D. STREET ADDRESS (If rural, give location) <b>3913 MYRTLE AVE.</b>		53-00	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>02/05/07</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTAR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Construction UNEMPLOYED</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>JOHN SCHUCK (DEC'D)</b>		14. MOTHER'S MAIDEN NAME <b>ANNA FRANKLIN (DEC'D)</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215 03 8722</b>		17. INFORMANT <b>ST AGNES HOSPITAL HOSPITAL RECORD</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>POSSIBLE CARCINOMA OF THE RIGHT LUNG</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/18 1967</b> to <b>11/19 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/19 1967</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>RODOLFO M. REVILLA</b>		23D. ADDRESS <b>ST AGNES HOSPITAL-CATON &amp; WILKENS AVE.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-22-1967</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Ritchie Hgwy., A.A.Co., Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 21 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>George J. Gonce-4001 Ritchie Hgwy., Baltimore</b>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 11133		HANNUM		CITY HEALTH DEPT		CERTIFICATE OF DEATH		Registered No. 67 11133	
1. NAME OF DECEASED (Type or Print) Doris Hannum						2. DATE AND HOUR OF DEATH 11-19-67 4:25 PM					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 South Baltimore General Hospital						4. USUAL RESIDENCE (Where deceased lived. If institution, give address before admission) A. STATE B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) 808 Barbours Ct., Glen Burnie D. STREET ADDRESS (If rural, give location) Glen Burnie 52-00 M.D.					
5. SEX F	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH 7-28-35	9. AGE (In years) 32	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Dept Store		11. BIRTHPLACE (State or foreign country) Kaiser, W-Va.	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Lawrence Ashley						14. MOTHER'S MAIDEN NAME Irene Oden					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO						16. SOCIAL SECURITY NO. unknown		17. INFORMANT Bernard Hannum - 808 Barbours Court, Glen Burnie, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 434.11 (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) Congestive heart failure (B) Pulmonary edema (C) Cushing disease					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Adrenalectomy bilateral											
19A. DATE OF OPERATION 3-11-15-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED fair		20A. AUTOPSY (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? lung congestion					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 4:25, 11-19-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Song Seok Churf						23B. DATE SIGNED 11-19-67					
23C. PHYSICIAN'S NAME (Type) Dr. Novin						23D. ADDRESS M.D. 1213 Light St. Baltamr M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/22/67		24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Pk		24D. LOCATION (City, town, or county) (State) Elkridge Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 21 1967		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Singleton Funeral Home		ADDRESS Glen Burnie, Md.					

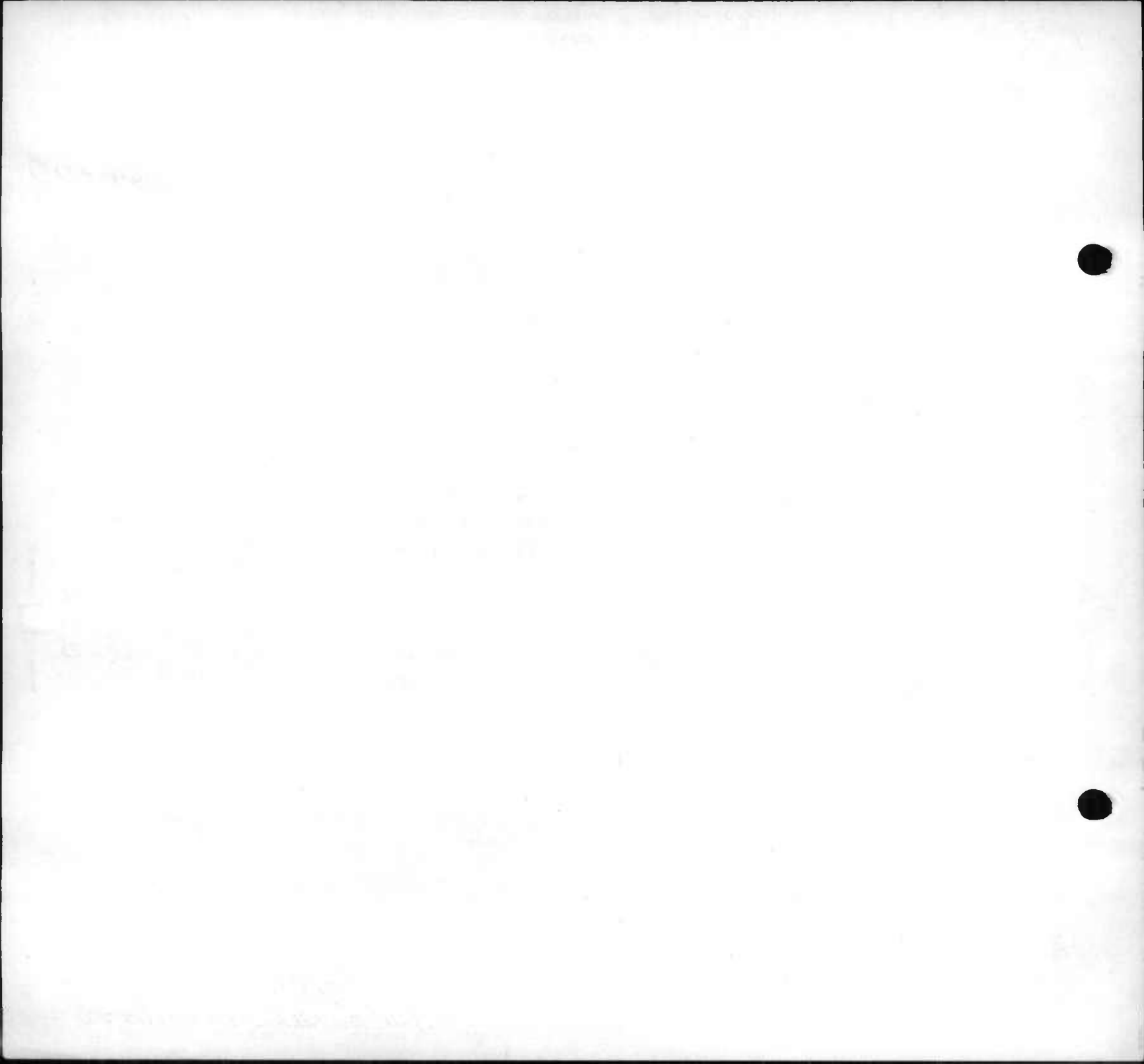
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

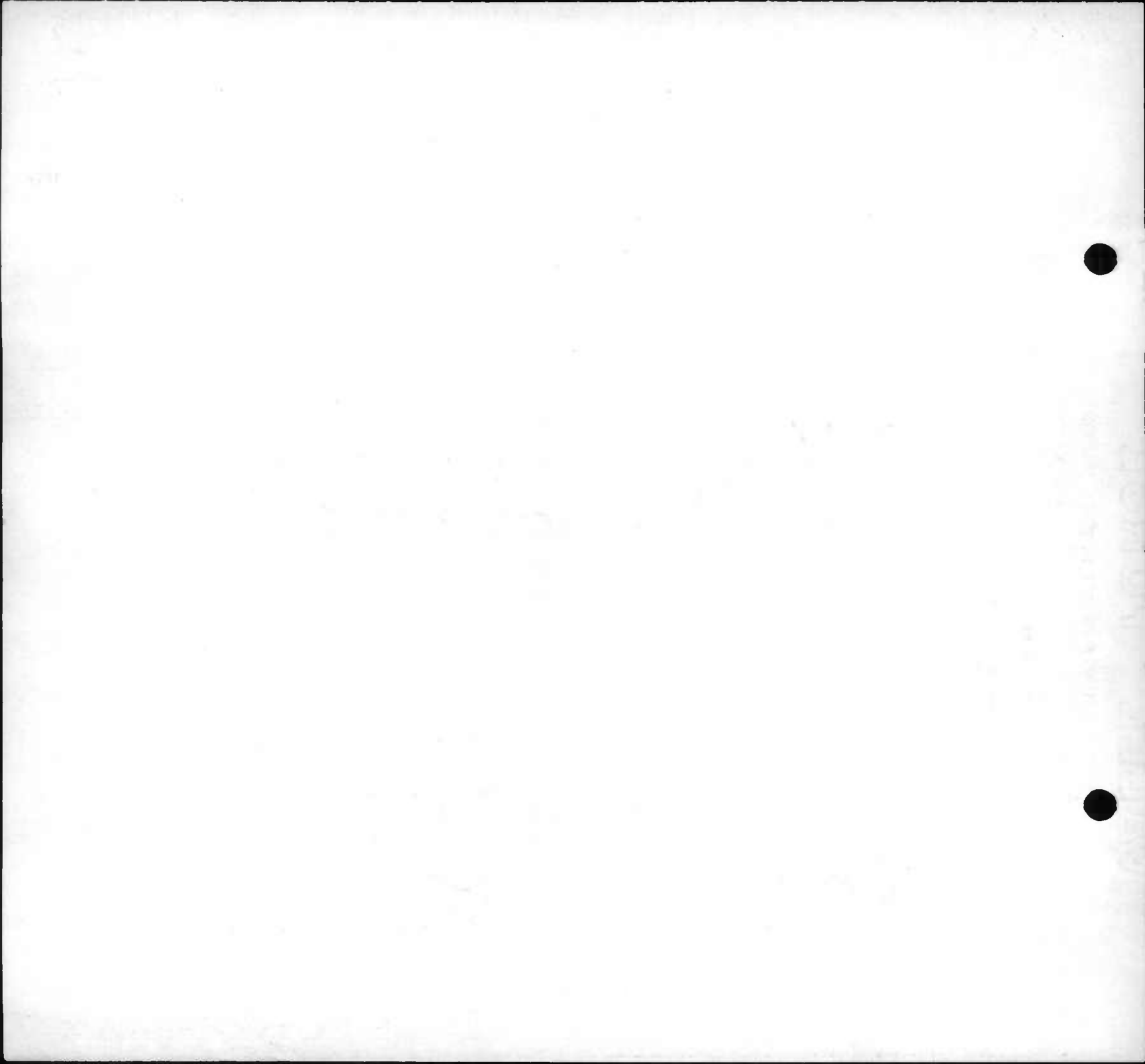
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 11134		67 11134		67 11134	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Mr. Joseph Reidy		November 10, 1967 12:00 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived; if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Bon Secours Hospital		Md. Prince Georges			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
M	W			Married	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
		Harlowe Typography Inc		Washington D.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
James J. Reidy		Nellie		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
W.W.II				Chart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) LIVER CIRRHOSIS with HEPATOMA.		3 YEARS	
ANTECEDENT CAUSES		(B) THROMBOSIS OF SUPERIOR Mesenteric Vein with 20% GANGRENE OF INTESTINE		3 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from NOV 7 1967 to NOV 10 1967, that (I) (we) last saw the deceased alive on NOV 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
J. W. [Signature]				Nov 10 '67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
500 WOODG. HONG				BON SECOURS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		15 Nov. 67		DRUID RIDGE	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 21 1967		Robert E. [Signature]		HANLON FUNERAL HOME - WASH. D.C.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11135		BALTIMORE CITY HEALTH DEPARTMENT		67 11135	
BIRTH NO.		M.E. CASE NO.		Registered No.	
1. NAME OF DECEASED (Type or Print) <b>ELIZABETH L. LOEFFLER</b>		2. DATE AND HOUR OF DEATH <b>NOV. 19, 1967</b>   <b>4 00</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b> <b>224 N. KENWOOD AVE.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> <b>6-02</b>			
		D. STREET ADDRESS (If rural, give location) <b>224 N. KENWOOD AVE.</b>			
5. SEX <b>F</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed.</b>	8. DATE OF BIRTH <b>7/9/1886</b>	9. AGE (In years lost birthday) <b>81</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>John C. LEUBECKER</b>			
14. MOTHER'S MAIDEN NAME <b>HELENA BUNNER</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>HELEN K. LOEFFLER 224 N. KENWOOD AVE.</b>			
18. <b>331 XI</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebro-vascular Accident</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO <b>Hypertension &amp; Atherosclerosis</b> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>August 16</b> 19 <b>67</b> to <b>Nov 19</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Nov 17</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Andrew Lemiscas</b> M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Andrew Lemiscas</b>		23D. ADDRESS <b>2608 E. BALTIMORE ST.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/22/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>OAK / OAK CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 21 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Tarkenton</b>		25C. FUNERAL DIRECTOR ADDRESS <b>B DABROWSKI 2818 E. BALTIMORE ST.</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11136

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

67 11136

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

BIRD, JOHN O. SR.

2. DATE AND HOUR OF DEATH

11/17/67

7:15 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

40 ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

4043 WILKENS AVENUE

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Married

8. DATE OF BIRTH

05/02/92

9. AGE (In years  
last birthday)

75

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

COOK

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

OSCAR BIRD

14. MOTHER'S MAIDEN NAME

MARY MASTERS

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

236-03-1642

17. INFORMANT

ADDRESS

ST. AGNES RECORDS-WILKENS &amp; CATON AVE.

18. 162.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Bronchogenic carcinoma  
metastatic

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 15, 1967 to NOVEMBER 17, 1967,  
that (I) (we) last saw the deceased alive on NOVEMBER 17, 1967 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

G. Braun

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

11/17/67

23C. PHYSICIAN'S  
NAME (Type)

G. BRAUN

23D. ADDRESS

M.D.

ST AGNES HOSPITAL - WILKENS &amp; CATON AV

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

11-21-67

24C. NAME OF CEMETERY or CREMATORY

Baltimore National Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

NOV 21 1967

R. E. Hubbard

Howard H. Hubbard, 4107 Wilkens Avenue 21229

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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 11137	
67 11137				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>HELEN LOSS</b>				<b>11-18-67 6:00 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>36 FRANKLIN SQUARE HOSPITAL</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>25-33</b> D. STREET ADDRESS (If rural, give location) <b>2357 ANNAPOLIS ROAD</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>9/11/91</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>RUSSIA</b>
13. FATHER'S NAME <b>UNKNOWN</b>			14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215 54 2092</b>	17. INFORMANT <b>FRANKLIN SQUARE HOSPITAL</b>		ADDRESS
18. <b>443 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>LOBAR PNEUMONIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Pulmonary Edema</b> <b>Hypertension, essential</b>			CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>NOV. 11</b> 19 <b>67</b> to <b>NOV. 15</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>NOV. 15</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ruben V. Luna</b> M.D.				23B. DATE SIGNED <b>11-18-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>RUBEN V. LUNA</b> M.D.				23D. ADDRESS <b>FRANKLIN SQUARE HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-21-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Trinity Church Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Elkridge, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 21 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b> ADDRESS <b>4107 Wilkens Avenue 21229</b>	

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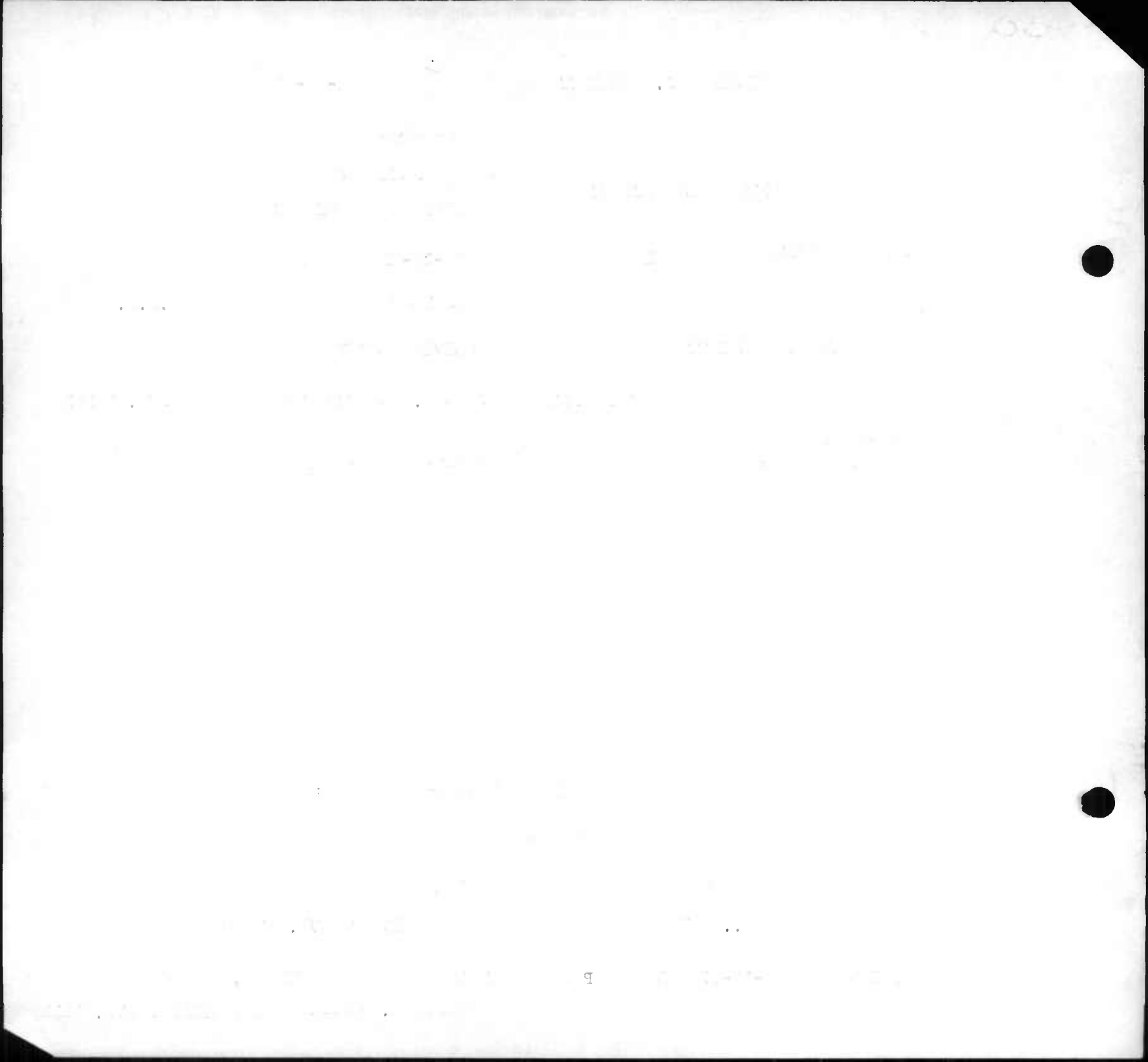
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

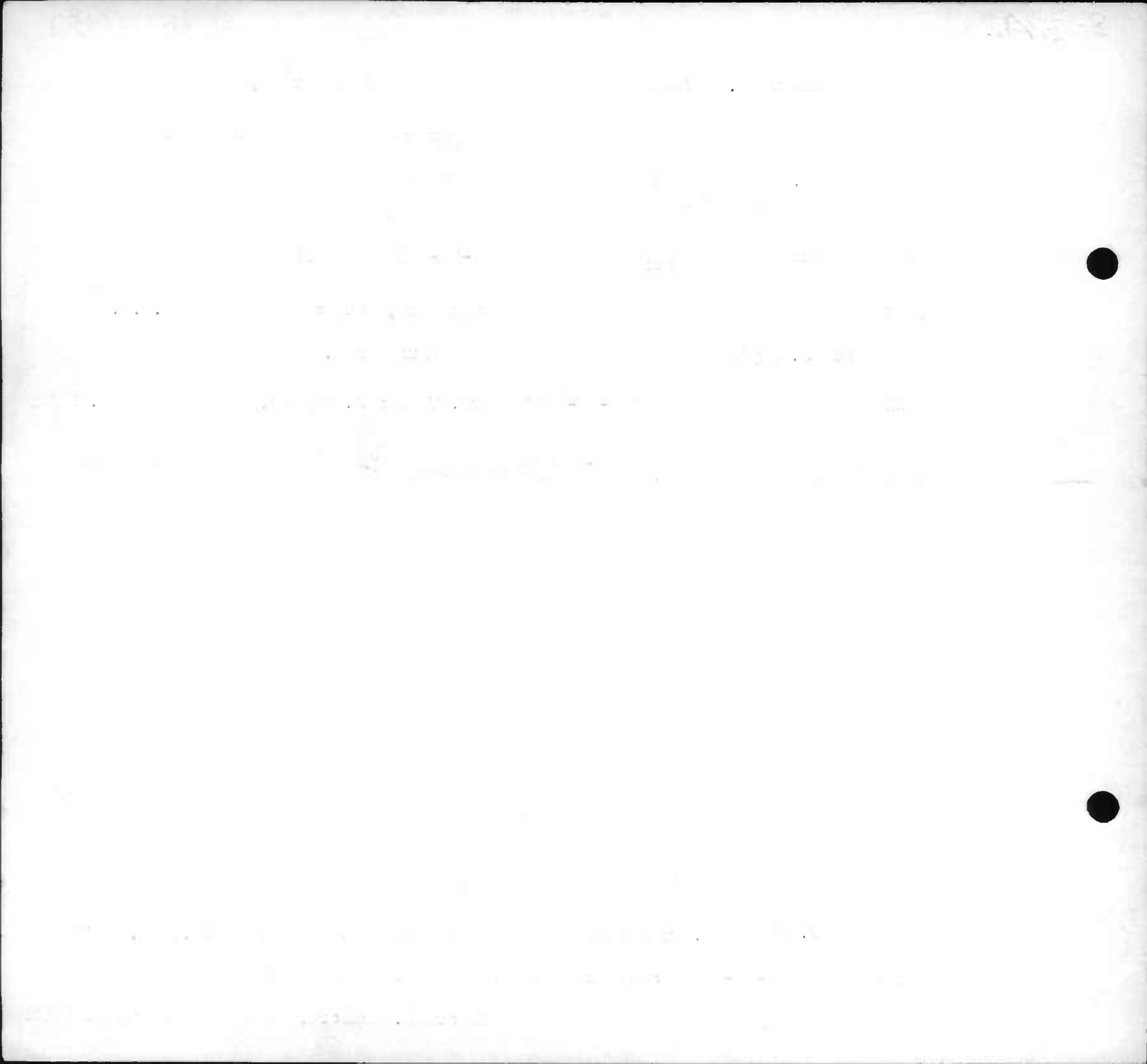
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 11138		67 11138		67 11138	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)			
		WILLIAM J. ELLIOTT			
2. DATE AND HOUR OF DEATH		11-18-67			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND			
1723 COLE STREET		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 1723 COLE STREET			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 10-20-13	9. AGE (In years last birthday) 54	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LUMBERMAN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JAMES ELLIOTT		14. MOTHER'S MAIDEN NAME OLIVIA CAVEY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215105729		17. INFORMANT ADDRESS JOHN K. ELLIOTT 2133 WILKENS AVE. 21223	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Carcinoma Lung</i> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH ?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>August</i> 1967 to <i>Nov</i> 1967, that (I) (we) last saw the deceased alive on <i>11 Oct</i> 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <i>H. Baylus</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>20 Nov 67</i>	
23C. PHYSICIAN'S NAME (Type) HERMAN H. BAYLUS		23D. ADDRESS M.D. 1600 WILKENS AVE. 21223			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-22-67		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK CEMETERY	
				24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. NOV 21 1967		25B. NAME OF REGISTRAR <i>Robert E. Falsky</i>		25C. FUNERAL DIRECTOR ADDRESS HOWARD H. HUBBARD 4107 WILKENS AVE. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

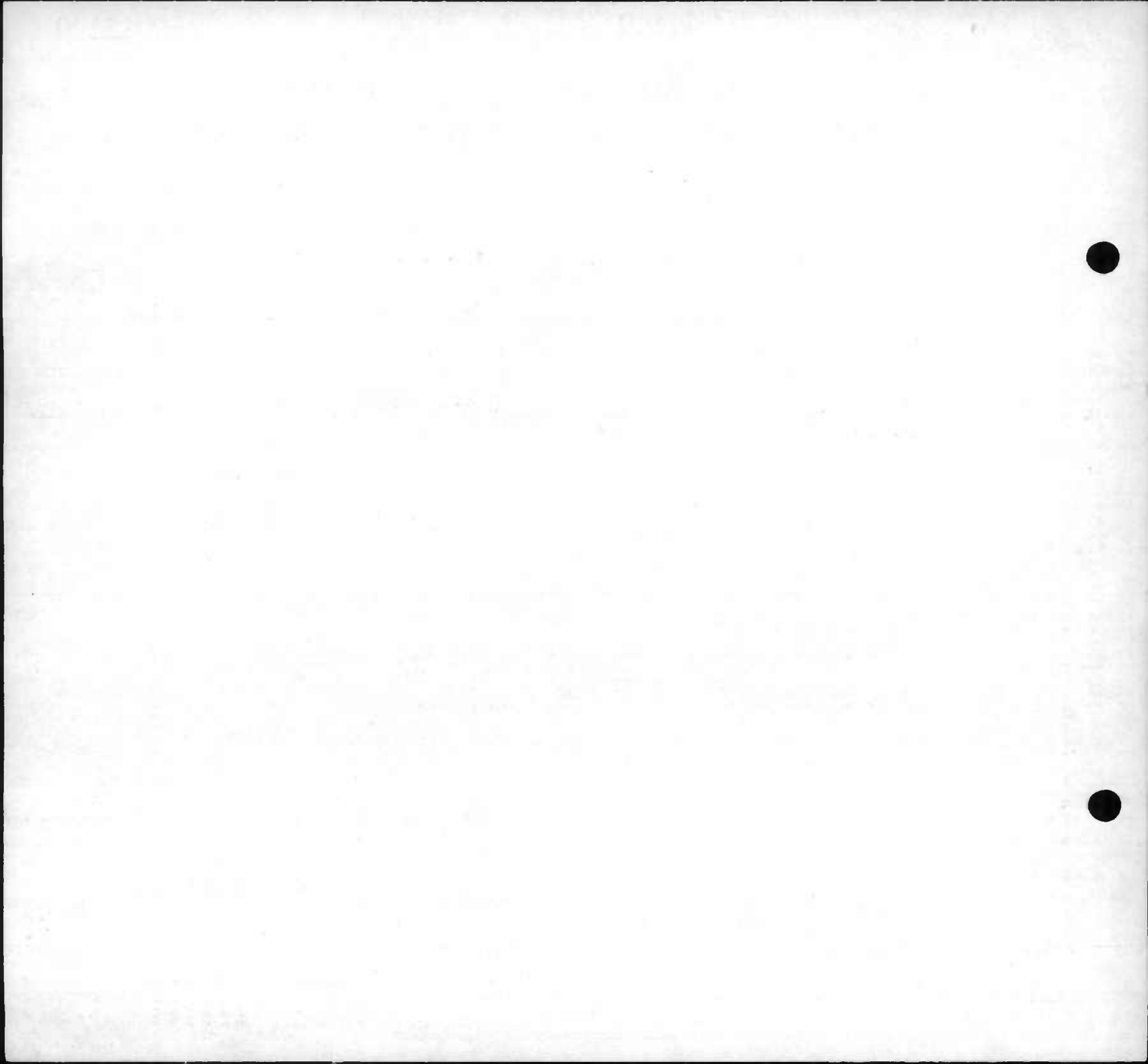
BALTIMORE CITY HEALTH DEPARTMENT									
67 11139 CERTIFICATE OF DEATH					Registered No. 67 11139				
BIRTH NO. 67 11139					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <b>ALBERT W. STYLES</b>					2. DATE AND HOUR OF DEATH <b>November 19, 1967</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Agnes Hospital</b> <b>Wilkins &amp; Caton Avenues</b>					A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Arbutus</b>				
					D. STREET ADDRESS (If rural, give location) <b>1026 Leeds Avenue</b>				
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>2-26-1914</b>	9. AGE (In years last birthday) <b>53</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Edward J. Styles</b>					14. MOTHER'S MAIDEN NAME <b>Frances A.</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>W W II</b>			16. SOCIAL SECURITY NO. <b>216-01-8880</b>		17. INFORMANT ADDRESS <b>Mrs. Thelma J. Styles, 1026 Leeds Ave. 21229</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>420.11</b> <b>Coronary Occlusion</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>July 1957</b> to <b>11/19 1967</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>11/19 1967</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>James N. Frederick</b>					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11/20/67</b>		
23C. PHYSICIAN'S NAME (Type) <b>Dr. James N. Frederick</b>					23D. ADDRESS <b>1311 Francis Avenue, Balto., Md. 21227</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-22-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 21 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkins Avenue 21229</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 11140					Registered No. 67 11140				
CERTIFICATE OF DEATH									
BIRTH NO. M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) Mrs. CSAPIE Sallie Hall					11-18-67 1:30 a.m.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 Mercy Hospital					A. STATE B. COUNTY 1315 Curie Way. Balt. 24 MD				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-36				
					D. STREET ADDRESS (If rural, give location)				
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 1-19-1895	9. AGE (In years last birthday) 72	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Ludwig Madl					14. MOTHER'S MAIDEN NAME Catherine Myers				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. —				
17. INFORMANT MILTON HALL					ADDRESS 9731 BIRD RIVER RD				
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 434.11									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input checked="" type="checkbox"/>			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input checked="" type="checkbox"/>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>			21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) (this hospital) attended the deceased from 11-1-67 11 p.m. to 11-18-67 3:30 a.m. that (I) (we) last saw the deceased alive on 11-18-67 3:09 a.m. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE A. Rahimi					23B. DATE SIGNED 11-18-67				
23C. PHYSICIAN'S NAME (Type) Abbas RAHIMI					23D. ADDRESS Mercy Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 11/21/67			24C. NAME of CEMETERY or CREMATORY ZION LUTHERAN			24D. LOCATION (City, town, or county) (State) BALTO. MD.
25A. DATE REC'D BY HEALTH DEPT. NOV 21 1967					25B. NAME OF REGISTRAR Philip E. Taylor				
					25C. FUNERAL DIRECTOR John J. Connelly, Sons				
					ADDRESS Essex 21, Md.				



1  
D-520

67 11141

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 11141

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

DOREEN DANOWSKI

2. DATE AND HOUR PRONOUNCED DEAD

November 16, 1967 4:20 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

35 Church Home &amp; Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

140 Wilshire Rd.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

JAN 28, 1924 43

9. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

SAMUEL BRAITHWAITE

14. MOTHER'S MAIDEN NAME

RUTH BRASHEAR

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

214-20-1967

17. INFORMANT

ALEXANDER DANOWSKI

ADDRESS

ABOVE

18.

E 903.5

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Subdural hemorrhage, right  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

20

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

In front of 140 Wilshire Rd.

21D. TIME  
OF INJURY  
(APPROX.)

10 31 67 1:45a

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Subject fell on pavement in front of

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from Natural causes ☒ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 17, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

11/20/67

23C. NAME OF CEMETERY or CREMATORY

SACRED HEART

23D. LOCATION

(City, town, or county)

BALTO. MD.

24A. DATE REC'D BY HEALTH DEPT.

NOV 21 1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

J.G. CONNELLY SONS

ADDRESS

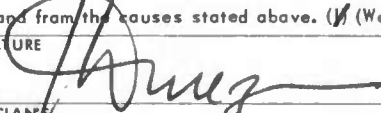
300 MACE

WALLACE  
FORD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67 11142</u>	
BIRTH NO. <u>67 11142</u>		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>STAEDTLER, BARBARA A.</u>	
2. DATE AND HOUR OF DEATH <u>11-18-67</u> <u>450</u> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Lutheran Hosp of Md.</u> <u>46</u>		A. STATE <u>Md.</u> B. COUNTY	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 6</u> <u>26-01</u>	
		D. STREET ADDRESS (If rural, give location) <u>4336 Berger Ave.</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>widowed</u>	8. DATE OF BIRTH <u>5-2-93</u>
			9. AGE (In years last birthday) <u>74</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Co. Maryland</u>
13. FATHER'S NAME <u>George C. Kroch</u>		14. MOTHER'S MAIDEN NAME <u>Pauline D. Neubauer</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-05-2272B</u>	
		17. INFORMANT ADDRESS <u>Mrs Loretta M. Bullen 4336 Berger Avenue 96</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>One mo. +</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Coronary Thrombosis</u> (C) <u>Arteriosclerotic Cardio-vascular Disease</u> <u>many yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>10-17</u> 19 <u>67</u> to <u>11-18</u> 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>10-17</u> 19 <u>67</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED <u>11-18-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>M.D.</u>		23D. ADDRESS <u>Lutheran Hosp</u> <u>M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-21-1967</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Schwartz Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 21 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>	
25C. FUNERAL DIRECTOR <u>Loseach Funeral Home 747 B. Lombol</u>		ADDRESS <u>36</u>	

43 9-5-3

15

4



B-212

67 11143 BALTIMORE CITY HEALTH DEPARTMENT

67 11143

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ANNA

NOGLYTE

BUJEVICIUS

2. DATE AND HOUR PRONOUNCED DEAD

November 18, 1967

4:30 P.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)CERTIFICATE AMENDED - 10/27/67  
University Hospital (DOA)4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

849 Hollins Street

5. SEX

Female

6. RACE

WHITE

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

1/9/1903

9. AGE (in years  
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR INDUSTRY

Domestic

11. BIRTHPLACE (State or foreign country)

Lithuania

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Victor NAUGLYTE

14. MOTHER'S MAIDEN NAME BRONAYAVA KRIDISKAS

ANNA KLEVICIUS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

-

17. INFORMANT

ADDRESS

Pedro Bujevicius - 849 Hollins St.

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S NAME (Type)  
Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/19/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/21/67

23C. NAME OF CEMETERY or CREMATORY

Landon Park Cem.

23D. LOCATION

(City, town, or county)

(State)

Balt. Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

NOV 21 1967

Robert E. Fisher, M.D.

John J. Cowan &amp; Son, Inc. 901 Hollins St.

Balt. Md.

10/27/70 - Letter from the Chief Medical Examiner,  
Herbert V. Spitz, M.D. signed 10/27/70. LBe.

1  
M-520

67 11144 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11144

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

GEORGE

J.

MUMMAUGH

2. DATE AND HOUR PRONOUNCED DEAD

November 17, 1967 11:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore Owings Mills 53-00

D. STREET ADDRESS (If rural, give location)

33 Ritters Lane

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Aug. 10, 1894

9. AGE (in years  
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

Congoleum-Nairn Co. Carroll Co., Md.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Nicholas F. Mummaugh

14. MOTHER'S MAIDEN NAME

Adelaide Shilling

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

216-07-4217

17. INFORMANT

Mrs. Hazel Z. Mummaugh, Owings Mills, Md.

ADDRESS

33 Ritters Lane

18.

E 812.4

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Cranio-Cerebral Injury

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Route 140 S. of Gwynnbrook Avenue

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
11/15/67 3:46 P.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by car 53-00

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/18/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/21/67

23C. NAME OF CEMETERY or CREMATORY

Evergreen Mem. Gardens

23D. LOCATION

(City, town, or county)

(State)

Finksburg, Carroll Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

NOV 21 1967

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

H. J. Schhardt

ADDRESS

Owings Mills, Md.

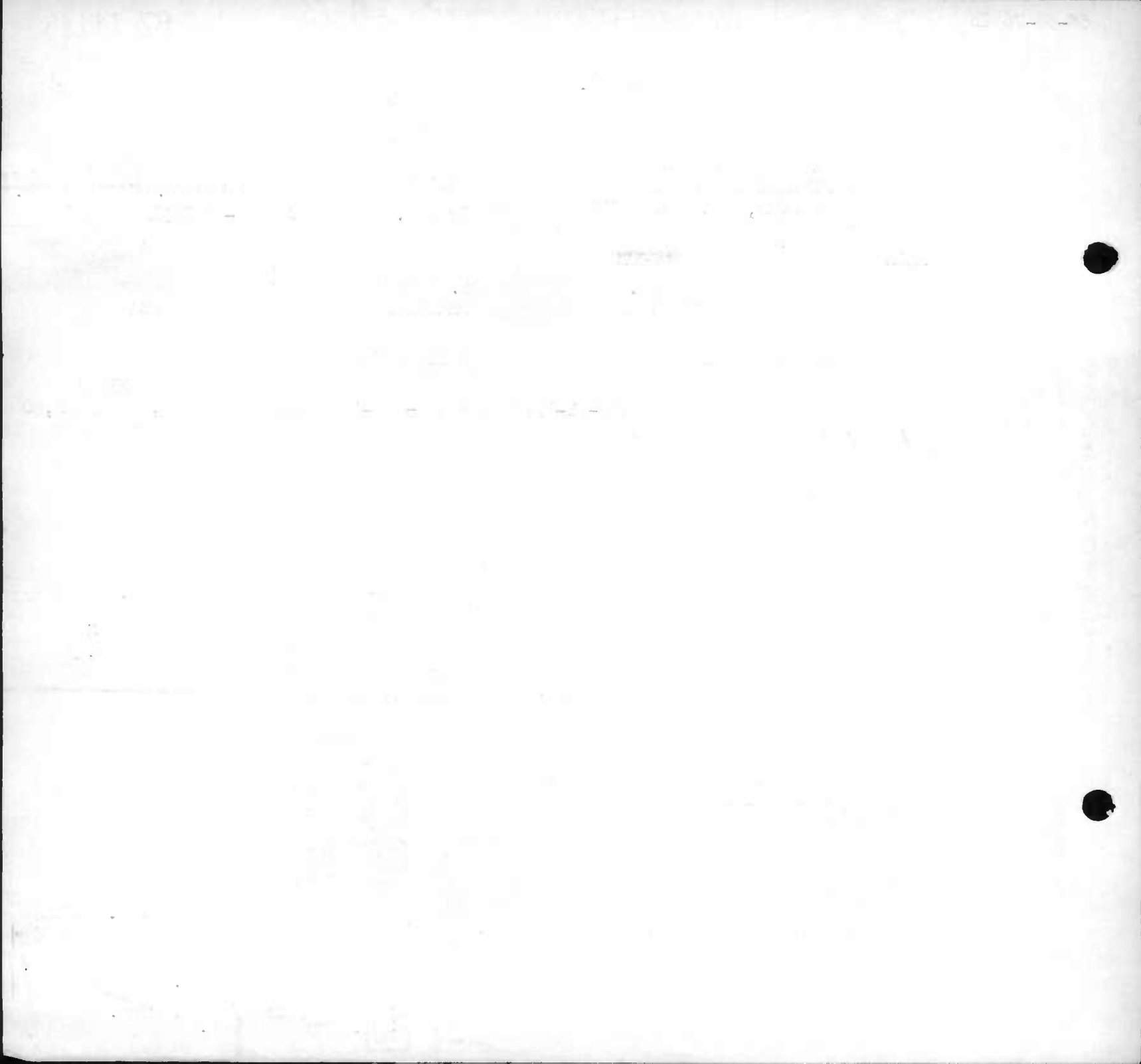
252

United States  
Department of State  
Washington, D.C.  
April 10, 1944  
Mr. [Name]  
[Address]  
[City]  
[State]

482224

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 9-300 67 11145				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11145	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>QUADE, THEODORE F.</b>				2. DATE AND HOUR OF DEATH <b>Nov. 18, 1967 1 330 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>101 N. GLOVER ST. 1906 E. KATHMOUNT AVE - #21231 21224</b>			
5. SEX <b>MALE</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>DIVORCED</b>	8. DATE OF BIRTH <b>4-6-92</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Balto. Transit Co MOTORMAN</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>BALTO. TRANSIT CO</b>		11. BIRTHPLACE (State or foreign country) <b>St. Mary's County MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>RICHARD QUADE</b>				14. MOTHER'S MAIDEN NAME <b>BETTY ANNE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>213 01-1352</b>		17. INFORMANT <b>RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>177X I</b> <b>CAUSE OF DEATH</b> <b>Cancer of prostate - metastases</b> <b>18 months</b>				19. INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 15</b> 19 <b>67</b> to <b>Nov 18</b> 19 <b>67</b> . that (I) (we) last saw the deceased alive on <b>Nov. 17</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Benjamin Lechner, M.D.</b>				23B. DATE SIGNED <b>Nov. 18, 1967</b>		23C. PHYSICIAN'S NAME (Type) <b>BENJAMIN LECHNER</b>	
23D. ADDRESS <b>Balt. City Hosp.</b>				23E. ADDRESS <b>BALTIMORE, MD. 21224 4940 EASTERN AVENUE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/21/67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 21 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		25D. ADDRESS <b>2601 E. Madison St.</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WHITEFORD, MR. CHARLES Austin

2. DATE AND HOUR OF DEATH

11/17/67

Registered No.

67 11146

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Balto.

D. STREET ADDRESS (If rural, give location)

1606 Chilton Street

5. SEX

♂

6. RACE

White

7. ~~MAARRIED~~ NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

12/28/09

9. AGE (In years last birthday)

57

If Under 1 Yr. Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Self emp.

10B. KIND OF BUSINESS OR INDUSTRY

lending floors

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Daniel M. Whiteford

14. MOTHER'S MAIDEN NAME

Anna Ank

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL SECURITY NO.

214-14-2167

17. INFORMANT

Madeline Schepper Whiteford, wife, above

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Cardiac arrest

(B) DUE TO

Myocardial infarction

(C)

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/17 1967 to 11/17 1967, that (I) (we) last saw the deceased alive on 11/17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

T. Limpawuchara M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11/17/67

23C. PHYSICIAN'S NAME (Type)

TAWEE LIMPAWUCHARA

23D. ADDRESS

THE UNION MEMORIAL HOSPITAL

TAWEE LIMPAWUCHARA M.D.

Union Memorial Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/21/67

24C. NAME OF CEMETERY OR CREMATORY

Gardens of Faith

24D. LOCATION

(City, town or county)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

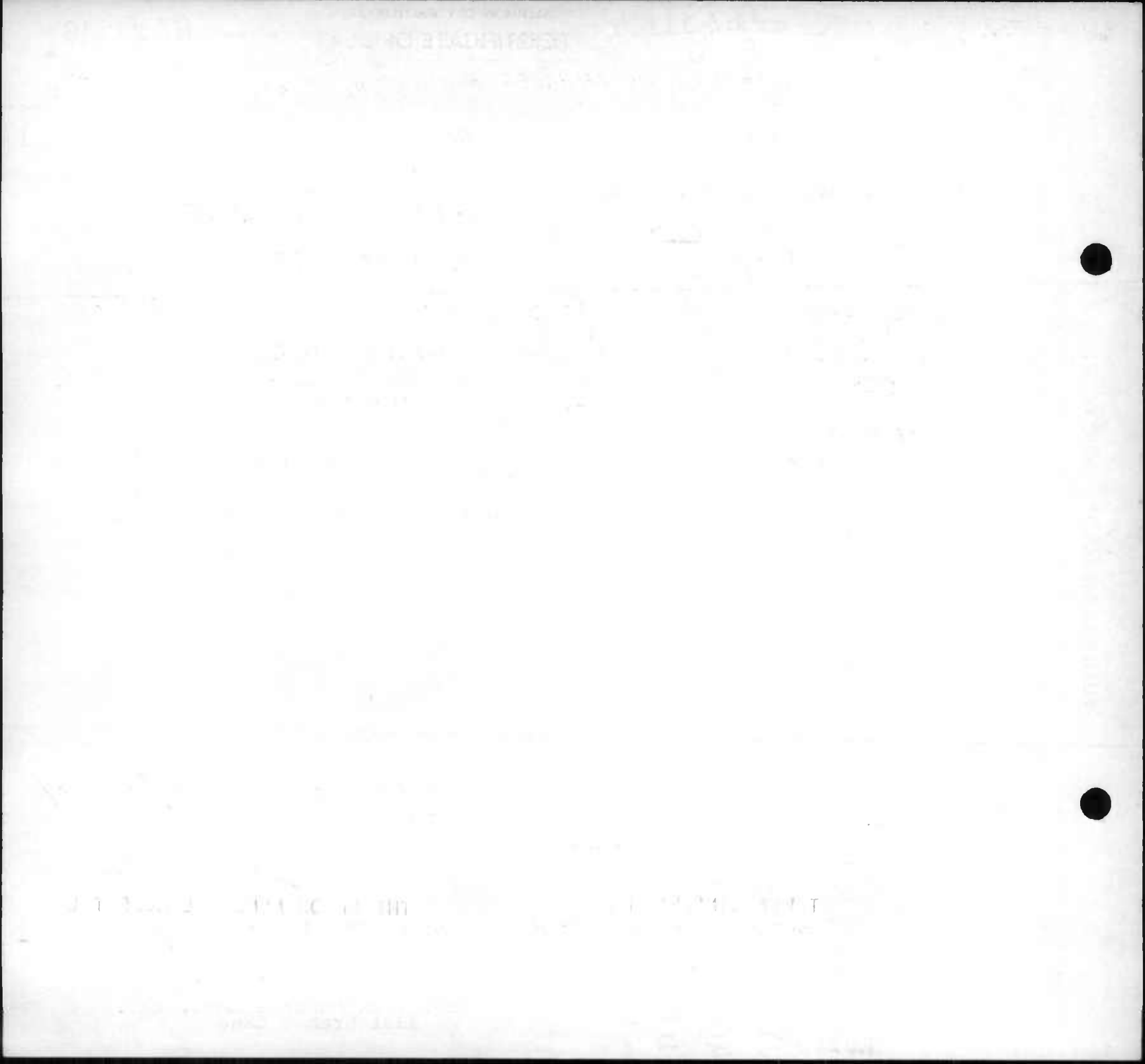
25C. FUNERAL DIRECTOR

ADDRESS

Schimunek Funeral Home, Inc.  
3331 Brehms Lane

VS 150-REV. 1

NOV 21 1967 Robert E. Johnson



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		67 11147		67 11147	
BIRTH NO.		M.E. CASE NO.		Registered No.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
O'HARA, John Michael		11-18-67		9:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
U.S.P.H.S. Hospital 3100 Wyman Park Dr BALTIMORE, MD		Maryland Baltimore			
28		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE 26-03			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
Male		Caucasian		Married	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
RETIRED U.S. AIR FORCE		U.S. Govt.		7-4-12	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
John O'HARA		SARA COUGHLIN		55	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes USAF 1532 - 1558		215 38 9597		above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Extreme Wastive and Negative Nitrogen balance			
ANTECEDENT CAUSES		(B) Disseminated Renal cell carcinoma			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		None			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Aug 7 1967 to Nov 18 1967, that (1) (we) last saw the deceased alive on Nov 18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
David S. Alberts		11-18-67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DAVID S. ALBERTS		U.S.P.H.S. Hospital, Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		11/22/67		Arlington National Cem	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 21 1967		R. E. E. Johnson		Schimunek Funeral Home, Inc. 3331 Brehms Lane	



67 11148

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11148

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JAMES

J.

WHITTY

2. DATE AND HOUR PRONOUNCED DEAD

November 17, 1967

6:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

3047 Gilford Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3047 Gilford Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

single

8. DATE OF BIRTH

4/24/1897

9. AGE (In years  
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

News Papers

10B. KIND OF BUSINESS OR INDUSTRY

self-employed

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Whitty

14. MOTHER'S MAIDEN NAME

Catherine Ready

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Edward Noonan, nephew, 3047 Gilford Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Hypertensive Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

11/18/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/22/67

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Schimunek Funeral Home, Inc.

3331 Brehms Lane

NOV 21 1967

MAHONEY RECORDS

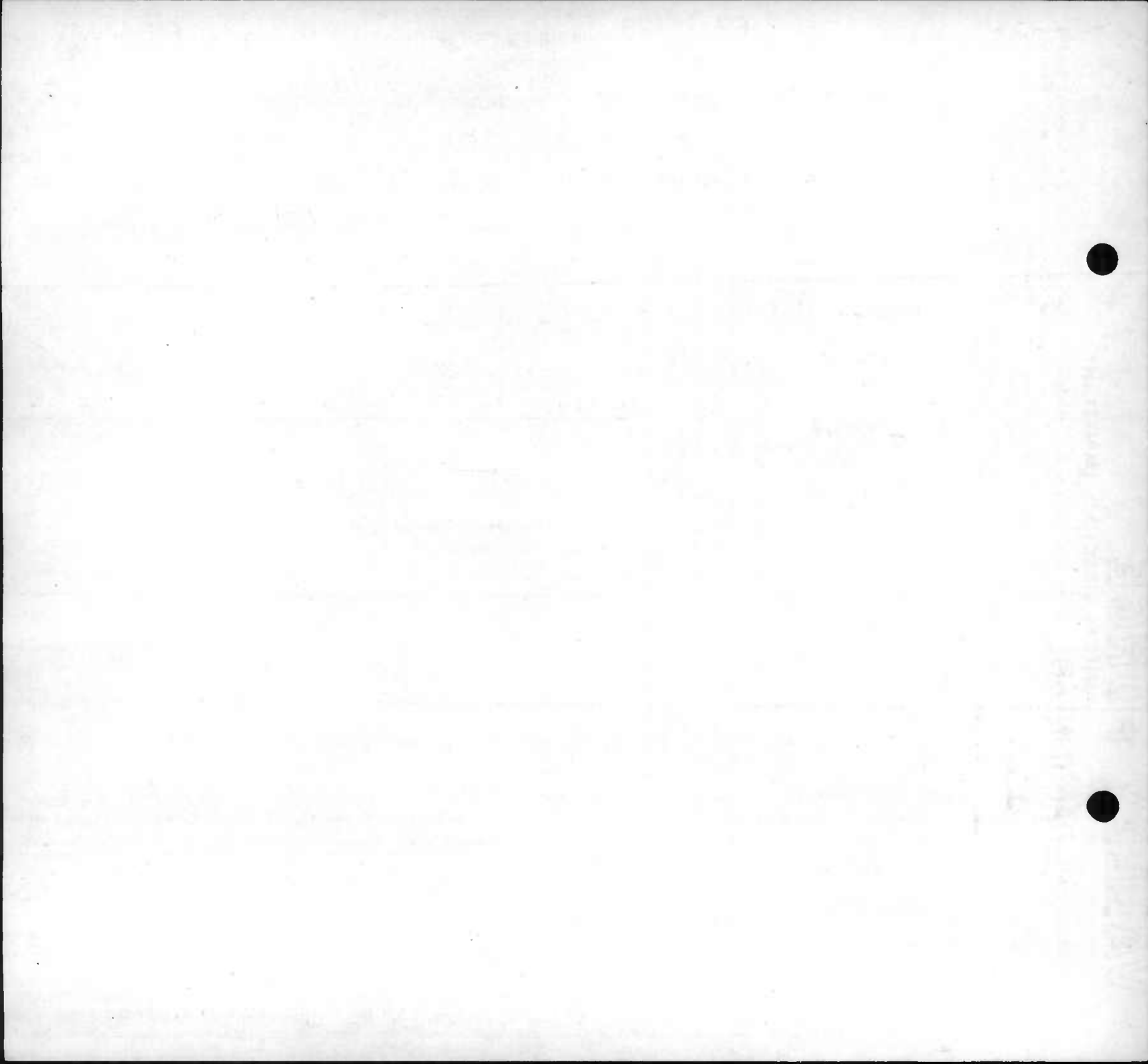
[Faint, illegible text, likely bleed-through from the reverse side of the page. The text appears to be organized into sections, possibly including a header, a list of items, and a footer. Some words like "MAHONEY" and "RECORDS" are visible in the left margin.]



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 11149</u>	
BIRTH NO. <u>67 11149</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>LAWRENCE Lewis L. Sr.</u>		2. DATE AND HOUR OF DEATH <u>11/18/67</u> <u>6:05</u> <u>A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Maryland General Hospital</u>		D. STREET ADDRESS (If rural, give location) <u>1433 Cedarcroft Rd.</u>		27-38	
5. SEX <u>Male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>2/11/84</u>	9. AGE (In years last birthday) <u>83</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>painter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John E. Lewis</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214 224806</u>		17. INFORMANT <u>Donald Lewis, son, 4430 Ebenezer Rd.</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) <u>Myocardial Infarction.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>General Debilitation.</u>		CAUSE OF DEATH (A) <u>Myocardial Infarction.</u> (B) <u>General Debilitation.</u> (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/15</u> <u>1967</u> to <u>11/18</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>11/18</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Anna...</u>		M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11/18/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. N. MARBITZ</u>		M.D.		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/21/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Parkwood Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 21 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. F...</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u>	
				ADDRESS <u>3331 Brehms Lane</u>	

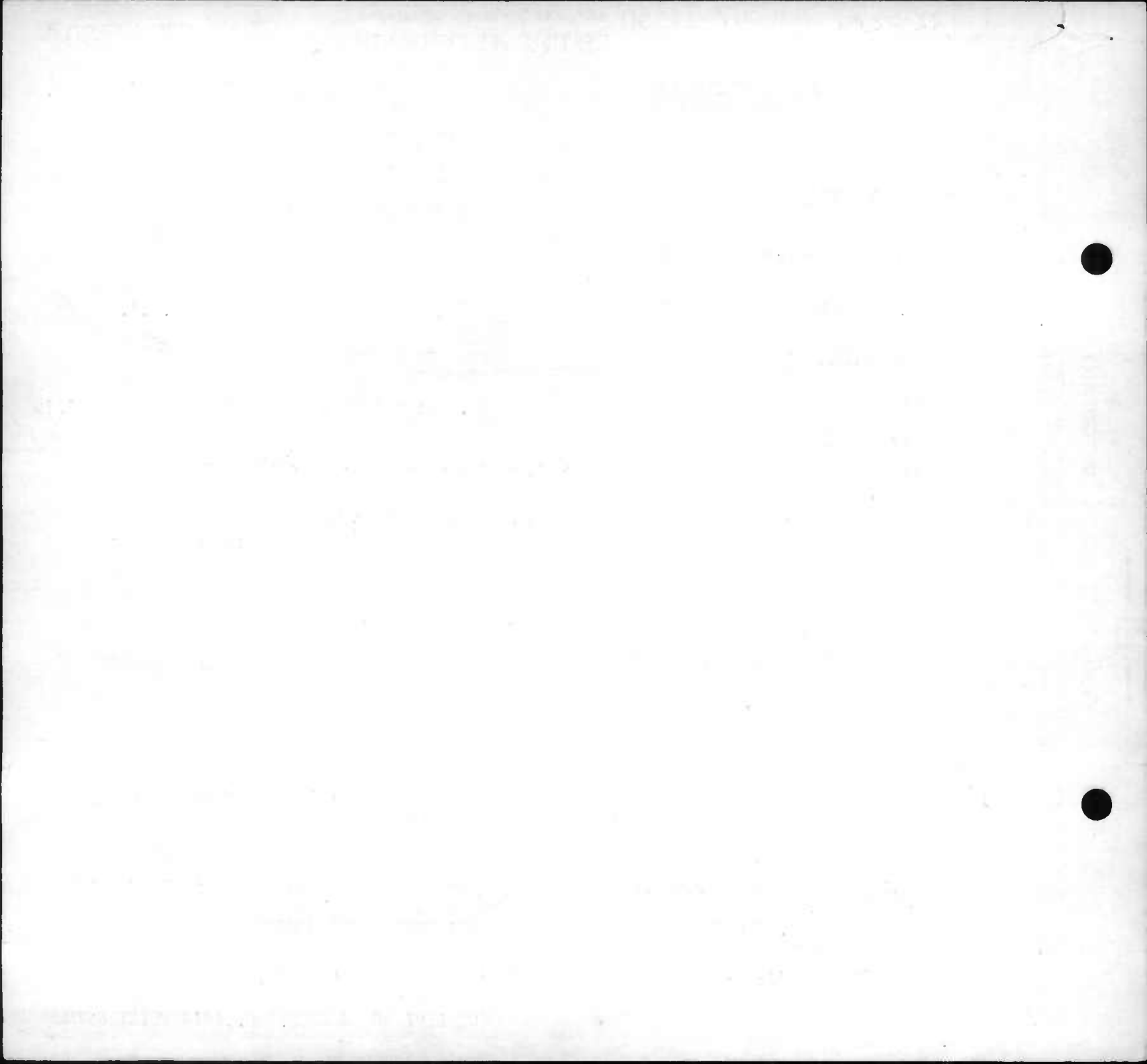




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

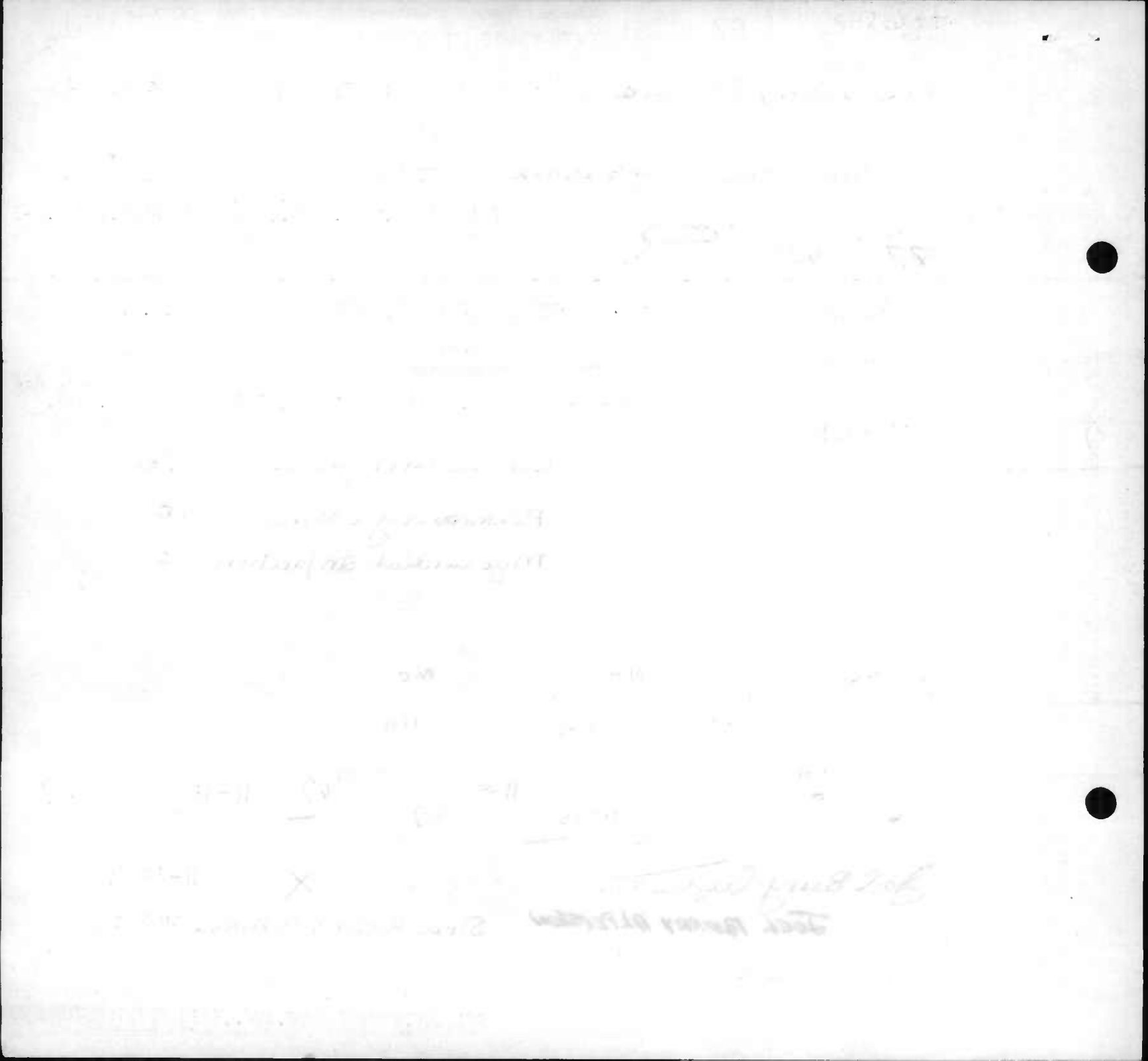
BIRTH NO. <span style="float: right;">67 11150</span>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="float: right;">67 11150</span>	
CERTIFICATE OF DEATH					
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>SARAH ROSENFELD</b>			NOVEMBER 15, 1967 12:21 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL</b>			A. STATE <b>MARYLAND</b> B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		
			D. STREET ADDRESS (If rural, give location) <b>3649 COTTAGE AVENUE</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>DAVID VEAX</b>			14. MOTHER'S MAIDEN NAME <b>ROSA ZIMMERMAN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>MRS. HILDA LURIE, 3649 COTTAGE AVENUE #21215</b>		
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO (B) <b>ARTERIOCLEROTIC CARDIOPATHY</b> DUE TO (C) <b>VERMINOUS DEMENTIA</b>		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Peptic ulcer</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 19 1960</b> to <b>November 15 1967</b> , that (I) (we) last saw the deceased alive on <b>November 15 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Cecil Rudner</b>				23B. DATE SIGNED <b>11-16-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. CECIL RUDNER</b>				23D. ADDRESS <b>6821 REISTERSTOWN ROAD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11-17-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>ANSHE EMUNAH AITZ CHAIN</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 21 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
67 11151		67 11151		67 11151	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO. <u>67 11151</u>		M.E. CASE NO. <u>4-652</u>			
1. NAME OF DECEASED (Type or Print) <u>ISADOR AARONSON</u>		2. DATE AND HOUR OF DEATH <u>11-15-67</u> <u>18:35</u> A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hospital of Baltimore</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BLATTMORRE</u>			
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	
8. DATE OF BIRTH <u>77</u>		9. AGE (In years last birthday) <u>77</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CITY OF BALTIMORE</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>MAX AARONSON</u>		14. MOTHER'S MAIDEN NAME <u>DORA ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-09-8692</u>		17. INFORMANT <u>MRS. NELLIE AARONSON, 7012 PARK HIGHTS, AVE.</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Cardiac arrhythmias</u> DUE TO (B) <u>Pulmonary edema</u> DUE TO (C) <u>Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>10</u> <u>8 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>NA</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NA</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NA</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NA</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>NA</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>NA</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>11-9</u> <u>1967</u> to <u>11-15</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>11-15</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Joel Barry Alperstein</u> M.D.				23B. DATE SIGNED <u>11-15-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOEL BARRY ALPERSTEIN</u> M.D.				23D. ADDRESS <u>Sinai Hospital Baltimore Md 21215</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11-17-67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BETH YEHUDA ANSHE KURLAND</u>	
24D. LOCATION (City, town, or county) <u>BALTIMORE, MARYLAND</u>		24E. NAME OF REGISTRAR <u>Robert E. Schuyler</u>		24F. FUNERAL DIRECTOR <u>\$OL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 1 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Schuyler</u>		25C. FUNERAL DIRECTOR <u>\$OL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD</u>	



# FUNERAL DIRECTOR: IMPORTANT

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R-150 BIRTH NO.		67 11152 BALTIMORE CITY HEALTH DEPARTMENT		67 11152 Registered No.	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>SAMUEL RUBIN</b>				2. DATE AND HOUR OF DEATH <b>NOVEMBER 16, 1967</b> <b>1 P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>4807 REISTERSTOWN ROAD</b> <b>00</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>28-31</b> D. STREET ADDRESS (If rural, give location) <b>4807 REISTERSTOWN ROAD</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>68</b>	9. AGE (In years last birthday) <b>68</b>	10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAPER HANGER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>		11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>	
13. FATHER'S NAME <b>UNKNOWN</b>			14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-30-1152</b>		17. INFORMANT <b>MRS. SONIA RUBIN, 4807 REISTERSTOWN RD. #21215</b>	
18. <b>420.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>None</b>				CAUSE OF DEATH (A) <b>Cerebral Thrombosis</b> DUE TO (B) <b>Arteriosclerotic Heart Disease</b> DUE TO (C) <b>None</b>  INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 year</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>this hospital</del> attended the deceased from <b>Nov 16</b> 1966 to <b>Nov 16</b> 1967, that (I) (we) last saw the deceased alive on <b>Nov 16</b> 1967 and that in (my) <del>four</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>Manuel Levin</b>				23B. DATE SIGNED <b>11/17/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. MANUEL LEVIN</b>				23D. ADDRESS <b>6101 PARK HEIGHTS AVENUE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11-17-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>BETH ISRAEL ADAS ISRAEL</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>NOV 21 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Seaborn</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD.</b>			

Charles Thompson  
Robert Lee Johnson

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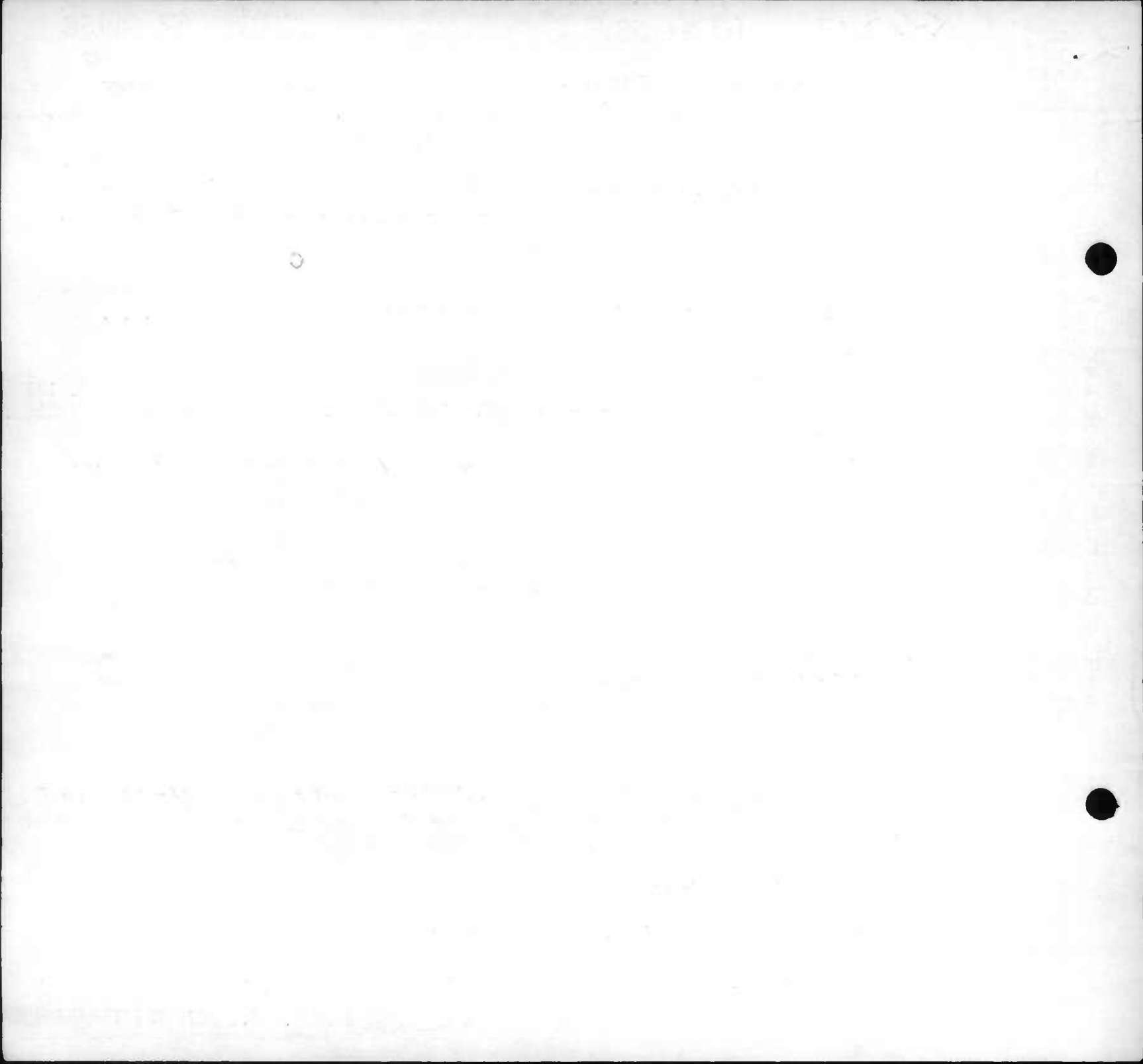
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# FUNERAL DIRECTOR: IMPORTANT

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<b>BALTIMORE CITY HEALTH DEPARTMENT</b> Registered No. <span style="float: right;">67 11153</span>	
<b>CERTIFICATE OF DEATH</b>	
BIRTH NO. <span style="float: right;">67 11153</span> M.E. CASE NO. <span style="float: right;">510</span> 1. NAME OF DECEASED (Type or Print) <span style="float: right;">KIRSON, EMMA</span> 2. DATE AND HOUR OF DEATH <span style="float: right;">NOV-15-67</span> <span style="float: right;">5:10 P M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 2em;">42</span> <span style="font-size: 1.5em;">SINAI HOSPITAL</span>	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="float: right;">MARYLAND</span> B. COUNTY <span style="float: right;">BALTIMORE</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">3219 Spaulding Ave. #15</span>	
5. SEX <span style="float: right;">FEMALE</span> 6. RACE <span style="float: right;">WHITE</span> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="float: right;">WIDOWED</span>	8. DATE OF BIRTH <span style="float: right;">?</span> 9. AGE (If years lost birthday) <span style="float: right;">80</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">HOUSEWIFE</span>	10B. KIND OF BUSINESS OR INDUSTRY <span style="float: right;">AT HOME</span>
11. BIRTHPLACE (State or foreign country) <span style="float: right;">EUROPE RUSSIA</span>	12. CITIZEN OF WHAT COUNTRY? <span style="float: right;">U.S.A.</span>
13. FATHER'S NAME <span style="float: right;">AARON GLASSER</span>	14. MOTHER'S MAIDEN NAME <span style="float: right;">BESSIE ?</span>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="float: right;">NO</span>	16. SOCIAL SECURITY NO. <span style="float: right;">216-10-0914</span>
17. INFORMANT ADDRESS <span style="float: right;">MR. AARON KIRSON, 7904 DUNHILL VILLAGE CIRCLE APT. 103</span>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.5em;">332 X1</span> <span style="float: right;">CVA (Left cerebral thrombosis)</span> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="float: right;">Cerebral Arteriosclerosis. Generalized Arteriosclerosis</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <span style="float: right;">-</span>	
19A. DATE OF OPERATION <span style="float: right;">11-14-67</span>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="float: right;">Tracheostomy (Respiratory Distress)</span>
20A. AUTOPSY? (Yes or No) <span style="float: right;">No</span>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <span style="float: right;">11-15-1967</span> to <span style="float: right;">11-15-1967</span> , that (I) (we) last saw the deceased alive on <span style="float: right;">11-15-1967</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <span style="font-size: 1.5em;">Francisco Saenz</span> M.D.	23B. DATE SIGNED <span style="float: right;">NOV-15-67</span>
23C. PHYSICIAN'S NAME (Type) <span style="float: right;">FRANCISCO SAENZ</span>	23D. ADDRESS <span style="float: right;">SINAI HOSPITAL H.O.</span>
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">BURIAL</span>	24B. DATE <span style="float: right;">11-16-67</span>
24C. NAME OF CEMETERY or CREMATORY <span style="float: right;">MIKRO KODESH BETH ISRAEL</span>	24D. LOCATION (City, town, or county) (State) <span style="float: right;">BALTIMORE, MARYLAND</span>
25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">NOV 21 1967</span>	25B. NAME OF REGISTRAR <span style="float: right;">Robert E. Fairbank</span>
25C. FUNERAL DIRECTOR <span style="float: right;">SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD</span>	ADDRESS

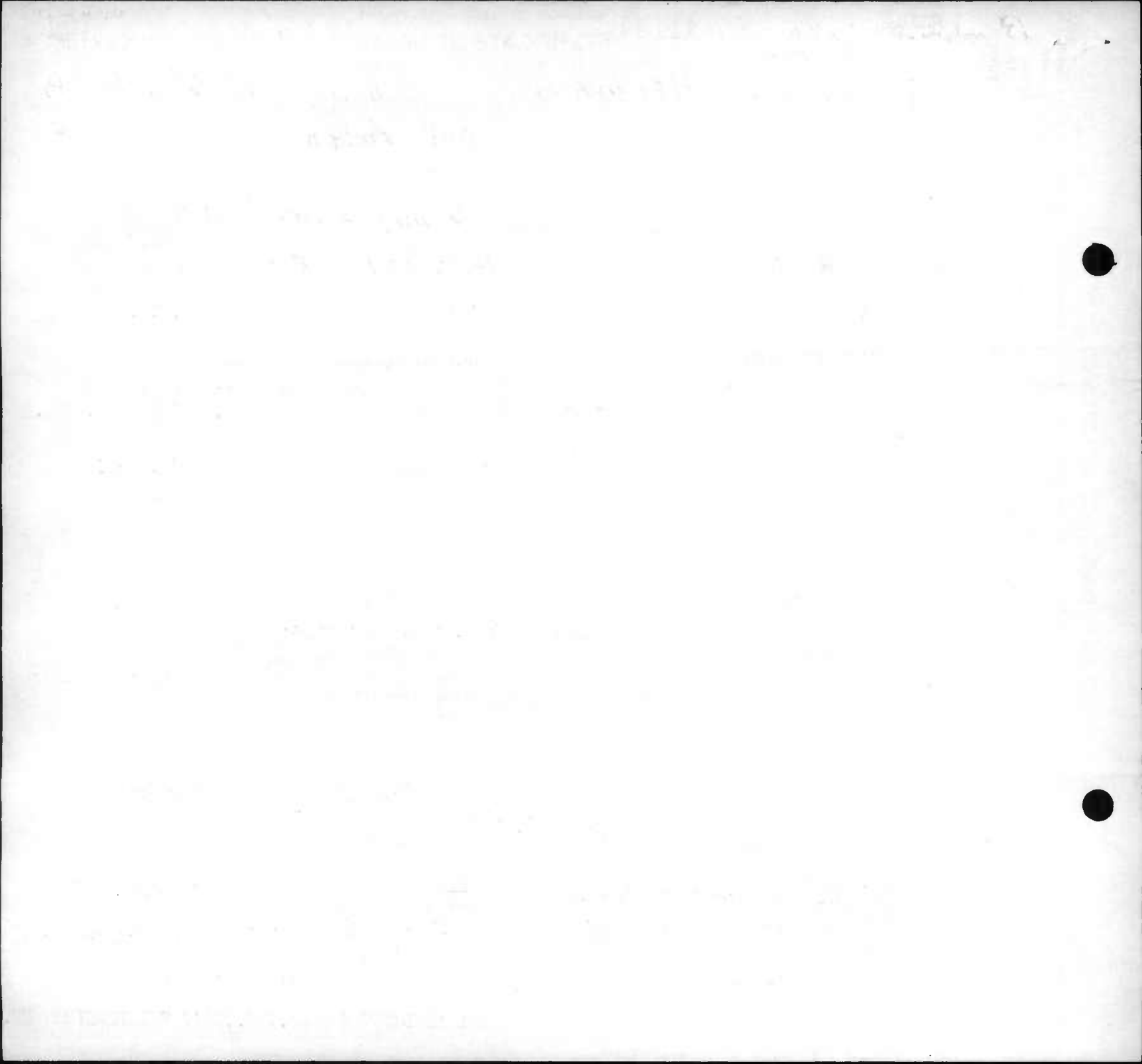




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <b>230 67 11154</b>		<b>CERTIFICATE OF DEATH</b>		67 11154	
M.E. CASE NO. <b>230 Pm.</b>					
1. NAME OF DECEASED (Type or Print) <b>Rosevich Herman</b>			2. DATE AND HOUR OF DEATH <b>Nov. 17, 1967 2:30 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MT. SINAI NURSING HOME</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>16 Maple Dr. #21220</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>10, 10, 1884</b>	9. AGE (In years last birthday) <b>83</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAILOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>BERNARD ROSEVICH</b>			14. MOTHER'S MAIDEN NAME <b>HANNAH PETLOCK</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>222-34-6296J</b>	17. INFORMANT ADDRESS <b>519 PHILADELPHIA PIKE</b> <b>SCHOENBERG MEMORIAL CHAPEL, WILMINGTON, DEL.</b>		
18. <b>422.1 + 260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetic Gangrene legs</b>			CAUSE OF DEATH (A) <b>ASCVD</b> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs</b>		
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/14/67</b> to <b>11/17/67</b> 19____, that (I) (we) last saw the deceased alive on <b>11/16/67</b> 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harvey S. Feuerman MD</b>			23B. DATE SIGNED <b>11/17/67</b>		
23C. PHYSICIAN'S NAME (Type) <b>Harvey S. Feuerman MD</b>			23D. ADDRESS <b>6210 Park Heights Ave #1315</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24B. DATE <b>11-18-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>NACHZIKEY HADAS</b>	
24D. LOCATION (City, town, or county) (State) <b>MINQUADALE, DELAWARE</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>NOV 21 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON, &amp; BROS. INC., 6010 REISTERSTOWN RD.</b>			



FUNERAL DIRECTOR: IMPORTANT

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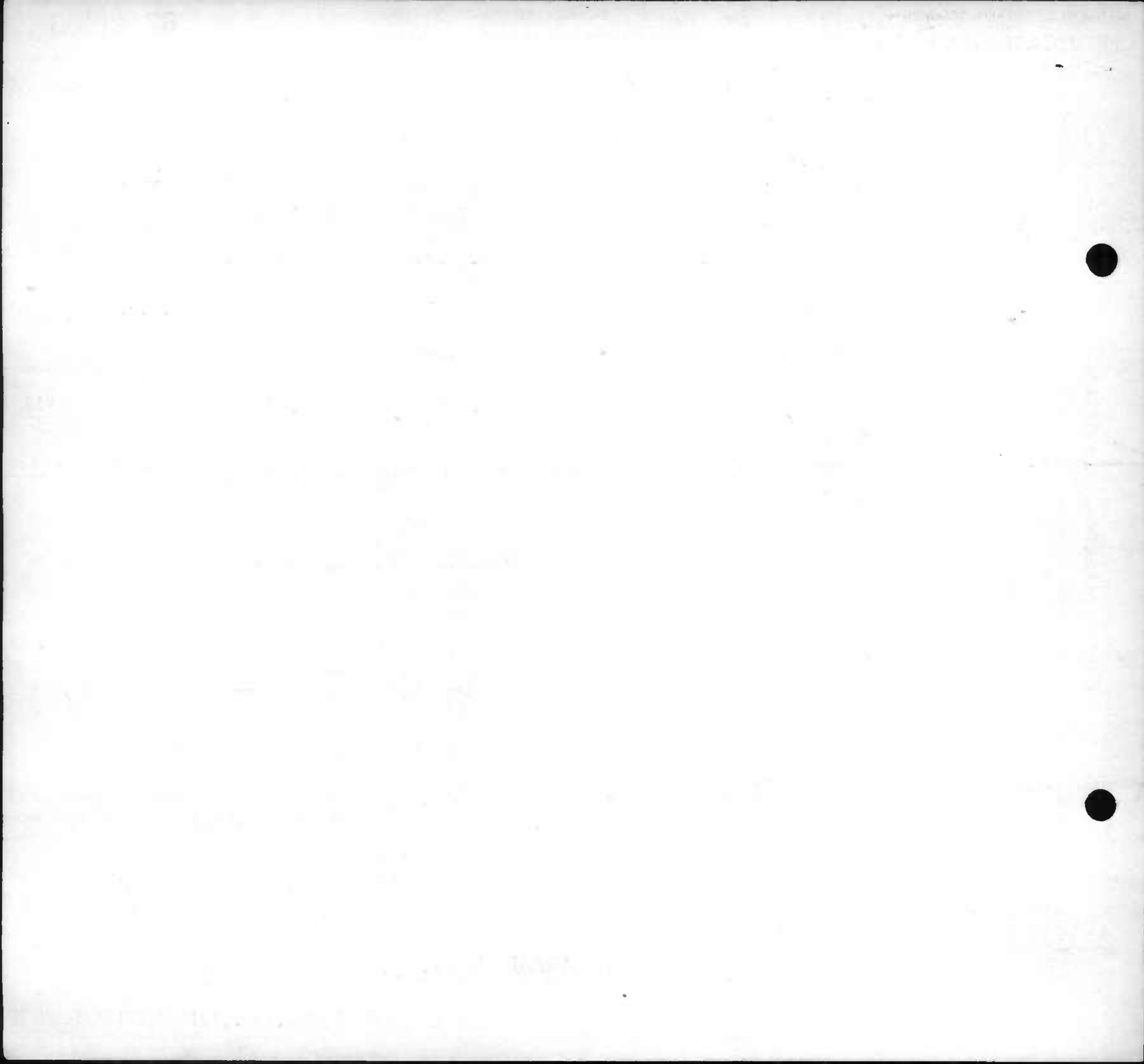
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 11155		67 11155	
CERTIFICATE OF DEATH					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Julius Herling		11/16/67 @ 9:40 PM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Maryland General Hospital		835 XXXXX XXXXX XXXXX XXXXX MARYLAND			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore, Maryland 13-01			
		D. STREET ADDRESS (If rural, give location)			
		835 LAKE DRIVE #21217			
5. SEX	6. RACE	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days
MALE	White	MARRIED	8-30-03	64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Salesman		MANAGER, MENS RETAIL CLOTHING		BALTIMORE, MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
MORRIS HERLING		MOLLIE ?		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		215-01-2540		WIFE MRS. FANNIE HERLING, 835 LAKE DR. #21217	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		minute	
ANTECEDENT CAUSES		(B) DUE TO		years.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
None					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11/16 to 11/16, 1967, that (I) (we) last saw the deceased alive on 11/16 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
C. S. Rofel				11/16/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				MARYLAND GENERAL HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		11-19-67		HEBREW FRIENDSHIP	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 21 1967		Robert E. Farkner		SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD.	
24D. LOCATION (City, town, or county) (State)		24E. LOCATION (City, town, or county) (State)			
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND			

Weyland Cover H.

# FUNERAL DIRECTOR: IMPORTANT

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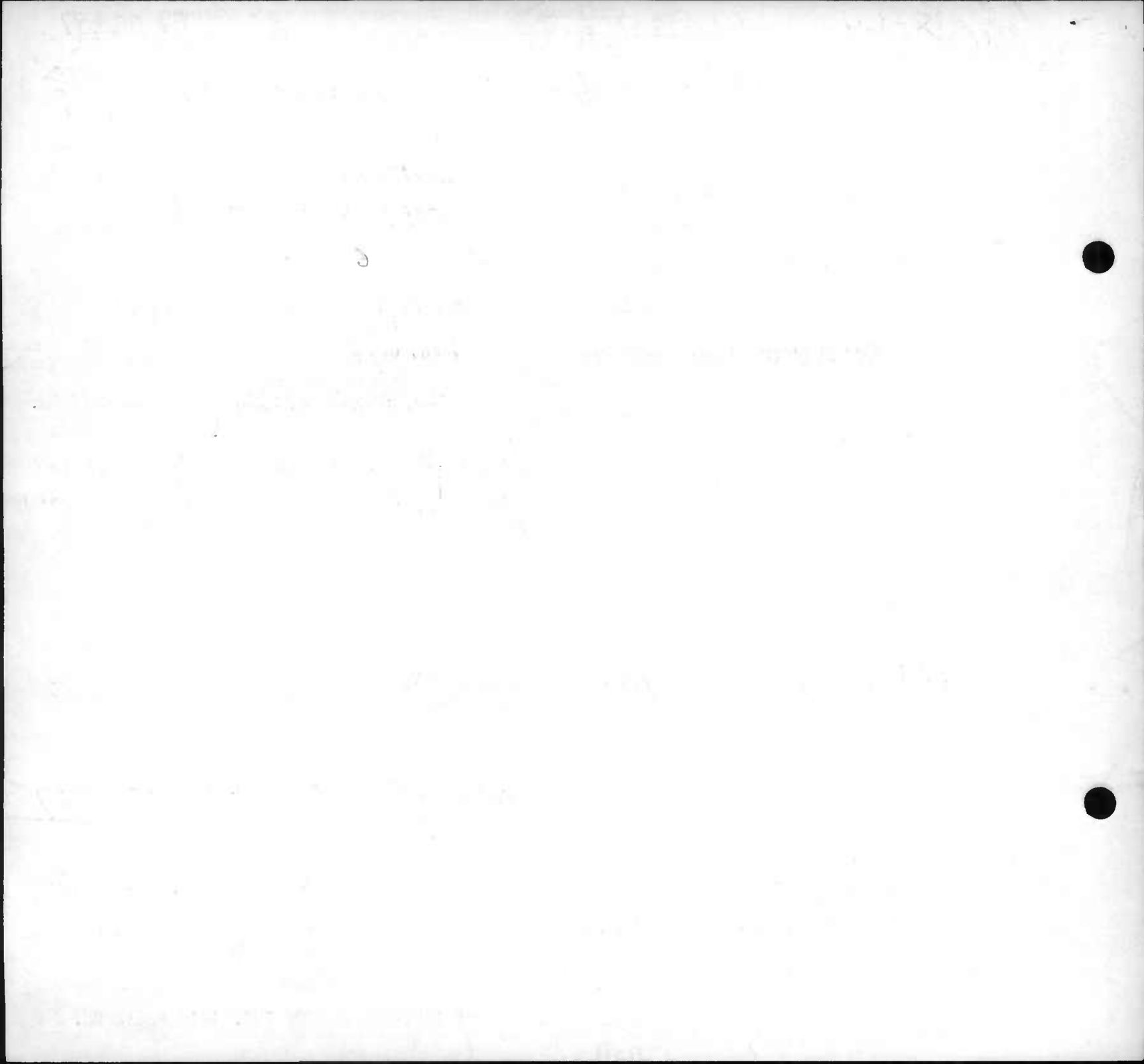
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
I-264		67 11156		67 11156	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Elizabeth Israel			11/16/67 11 45am M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Sinai Hospital of Balto			MARYLAND		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			BALTIMORE		
			D. STREET ADDRESS (If rural, give location)		
			7005 FIELDCREST ROAD		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
FEMALE	WHITE	MARRIED	9-30-1922	45	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		AT HOME		RUMANIA	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
DESIDERIU IJAC			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO					MR. MAURIDIU ISRAEL, 7005 FIELDCREST ROAD #15
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO		420.1 I Myocardial Infarction
ANTECEDENT CAUSES			(B) DUE TO		ASCVD
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO		Mitral insufficiency
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Kenneth Wetcher M.D.				11/16/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
KENNETH Wetcher M.D.				Sinai Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		11-17-67		ARUGAT HABOSEN	
				BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 21 1967		Sol Levinson		SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD	



FUNERAL DIRECTOR: IMPORTANT

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<p><b>BIRTH NO.</b> 1K-645 <b>67 11157</b></p> <p style="text-align: right;"><b>67 11157</b></p>		<p><b>CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p><b>Registered No.</b> 67 11157</p>	
<p><b>M.E. CASE NO.</b></p>		<p><b>1. NAME OF DECEASED</b> (Type or Print) <i>Samuel Kurlander</i></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <i>Nov. 18, 1967 7<sup>00</sup> P. M.</i></p>	
<p><b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>38 University Hospital</i></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence, before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i></p> <p>D. STREET ADDRESS (If rural, give location) <i>53-00 3327 Northmont Rd</i></p>			
<p><b>5. SEX</b> <i>Male</i></p>	<p><b>6. RACE</b> <i>White</i></p>	<p><b>7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)</b> <i>Married</i></p>	<p><b>8. DATE OF BIRTH</b> <i>Oct 26, 1886</i></p>	<p><b>9. AGE</b> (In years last birthday) <i>81</i></p>	<p><b>10. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Tailor</i></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <i>Clothing</i></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country) <i>Evansville Russia</i></p>	
<p><b>13. FATHER'S NAME</b> <i>Samuel Mayer Kurlander</i></p>			<p><b>14. MOTHER'S MAIDEN NAME</b> <i>Ethel</i></p>		
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p><b>16. SOCIAL SECURITY NO.</b></p>		<p><b>17. INFORMANT</b> <i>William Kurlander</i> ADDRESS <i>4104 Fallstaff Rd.</i></p>	
<p><b>18. CAUSE OF DEATH</b></p> <p><b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Metastatic carcinoma from colon</i></p> <p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p><b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b></p>					
<p><b>19A. DATE OF OPERATION</b> <i>Oct 27, 1967</i></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <i>Poor.</i></p>		<p><b>20A. AUTOPSY?</b> (Yes or No) <i>No</i></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from <i>October 19</i> 19 <i>67</i> to <i>Nov. 18</i> 19 <i>67</i>. that (I) (we) last saw the deceased alive on <i>Nov. 18</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>					
<p><b>23A. SIGNATURE</b> <i>Youngsik Moon</i> M.D.</p>				<p><b>23B. DATE SIGNED</b> <i>Nov. 18, 1967</i></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <i>Youngsik Moon</i></p>				<p><b>23D. ADDRESS</b> <i>University Hospital, Baltimore</i></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <i>BURIAL</i></p>		<p><b>24B. DATE</b> <i>11/19/67</i></p>		<p><b>24C. NAME of CEMETERY or CREMATORY</b> <i>Moses Montifiore</i></p>	
<p><b>24D. LOCATION</b> (City, town, or county) (State) <i>Baltimore, Maryland</i></p>		<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <i>NOV 21 1967</i> <b>25B. NAME OF REGISTRAR</b> <i>Paul E. Talbott</i></p>			
<p><b>25C. FUNERAL DIRECTOR</b> <i>SOL LEVINSON &amp; BROS INC.</i> ADDRESS <i>6010 Reist Rd.</i></p>					

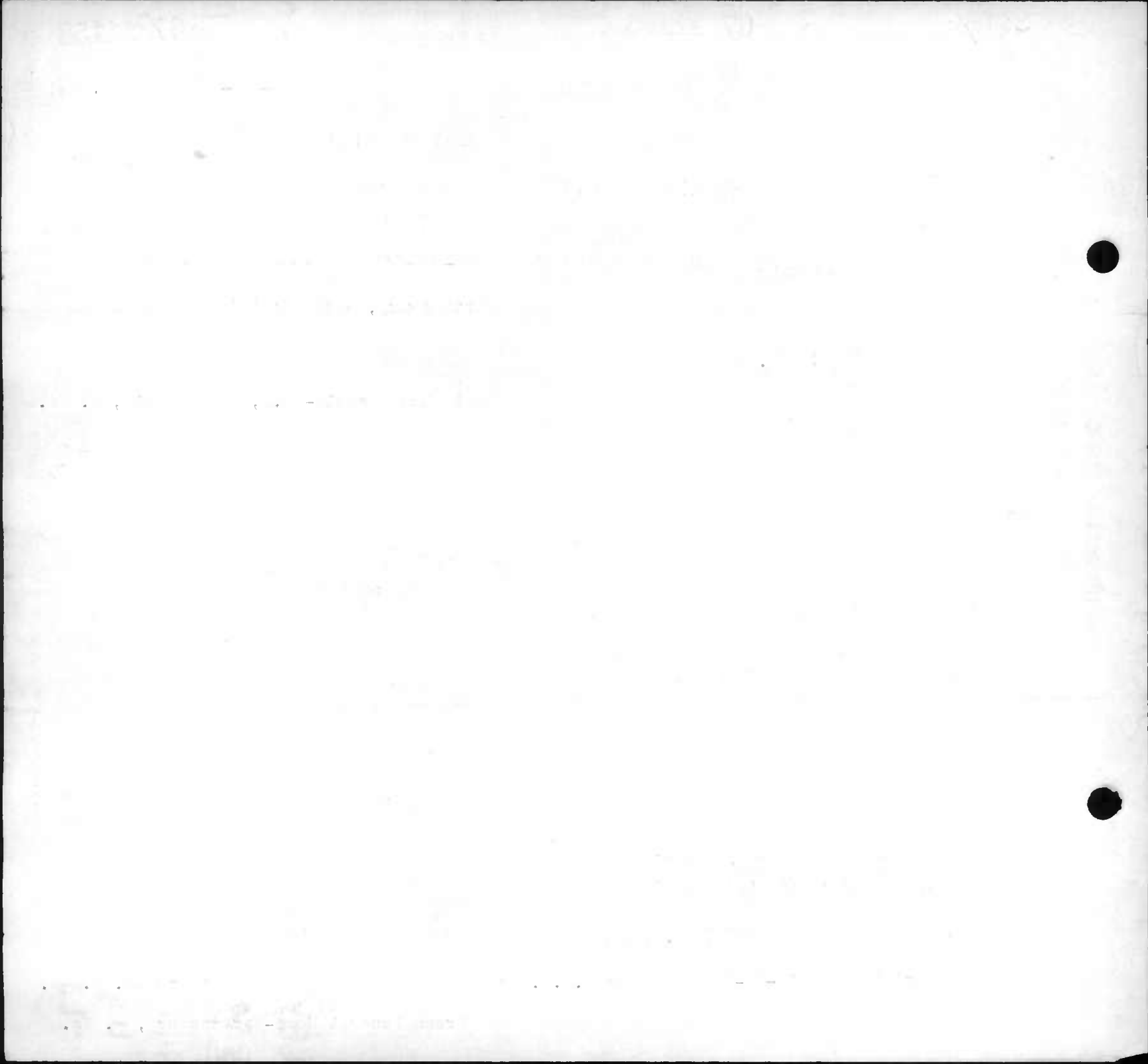




FUNERAL DIRECTOR: IMPORTANT

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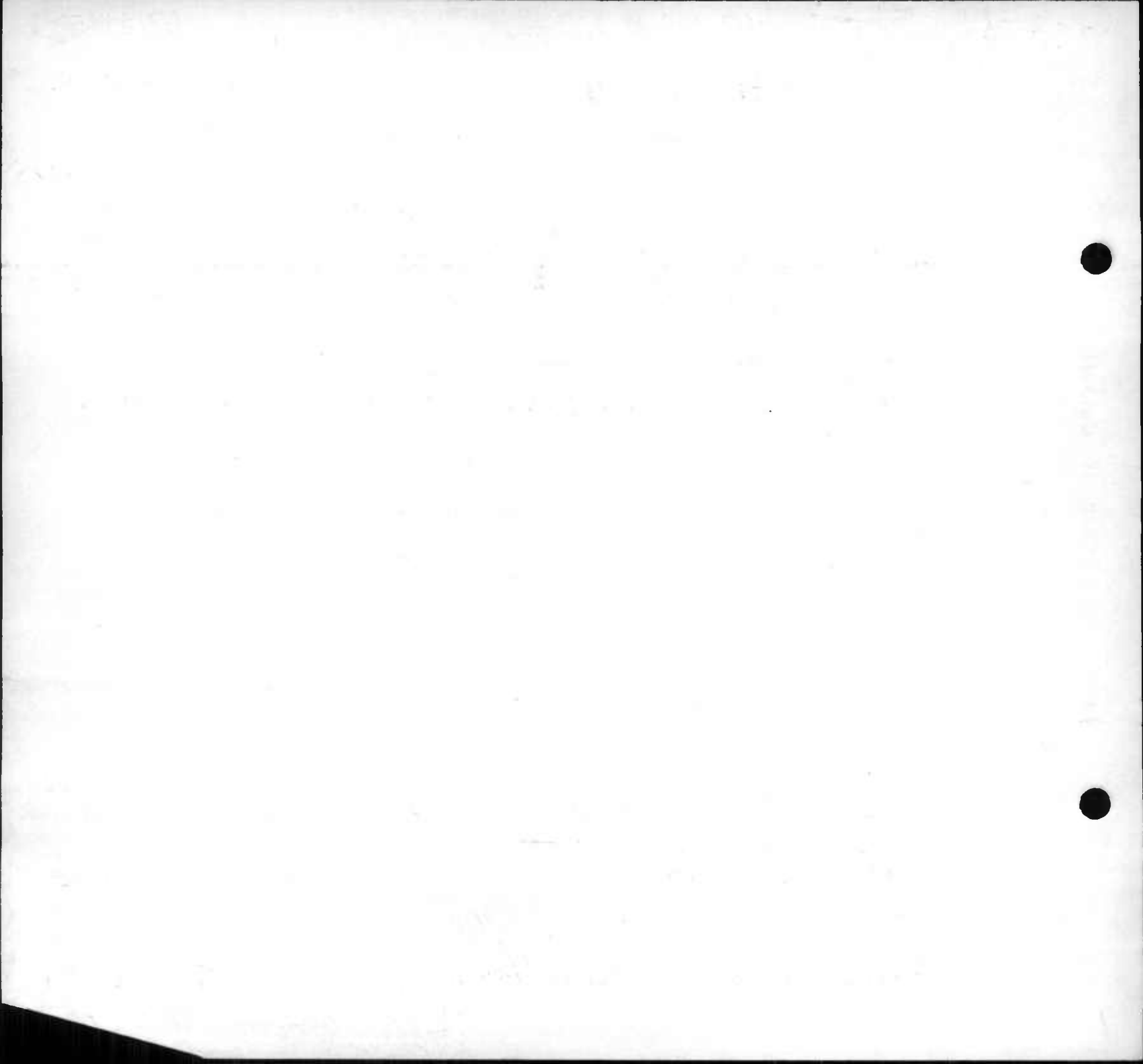
BIRTH NO. <i>West Va.</i> 67 11158		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 11158	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>DAVID VAN BABY BOY GOSNELL</b>			11-18-67 11.45P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 THE JOHNS HOPKINS HOSPITAL</b>			A. STATE <b>WEST VIRGINIA</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>HEDGESVILLE</b> D. STREET ADDRESS (If rural, give location) <b>ROUTE #3</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>11-14-67</b>	9. AGE (In years last birthday) <b>4</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <b>Martinsburg, West Virginia</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>DAVID L. GOSNELL</b>			14. MOTHER'S MAIDEN NAME <b>EDNA MARIE BOWERS</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>David Lee Gosnell-Rt.3, Hedgesville, W. Va.</b>
18. <b>754.71</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) DUE TO <b>Hypoxia, Anoxia, 5d.p</b> <b>poor perfusion</b> (B) DUE TO (C) <b>Transpiration of the</b> <b>Arterial Vessels</b>			INTERVAL BETWEEN ONSET AND DEATH		
II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>11/17/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Transposition of Great Arteries</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/14/67</b> 19 to <b>11/18</b> 1967, that (I) (we) last saw the deceased alive on <b>11/18</b> 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Robert S. Pipkin</i> M.D.				23B. DATE SIGNED <b>11/18/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROBERT S. PIPKIN</b>				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-20-1967</b>		24C. NAME OF CEMETERY or CREMATORY <b>Snyders E.U.B. Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Morgan Co. W. Va.</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>NOV 21 1967</b>			
25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>N. H. Brown</i> <b>Brown Funeral Home-Martinsburg, W. Va.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

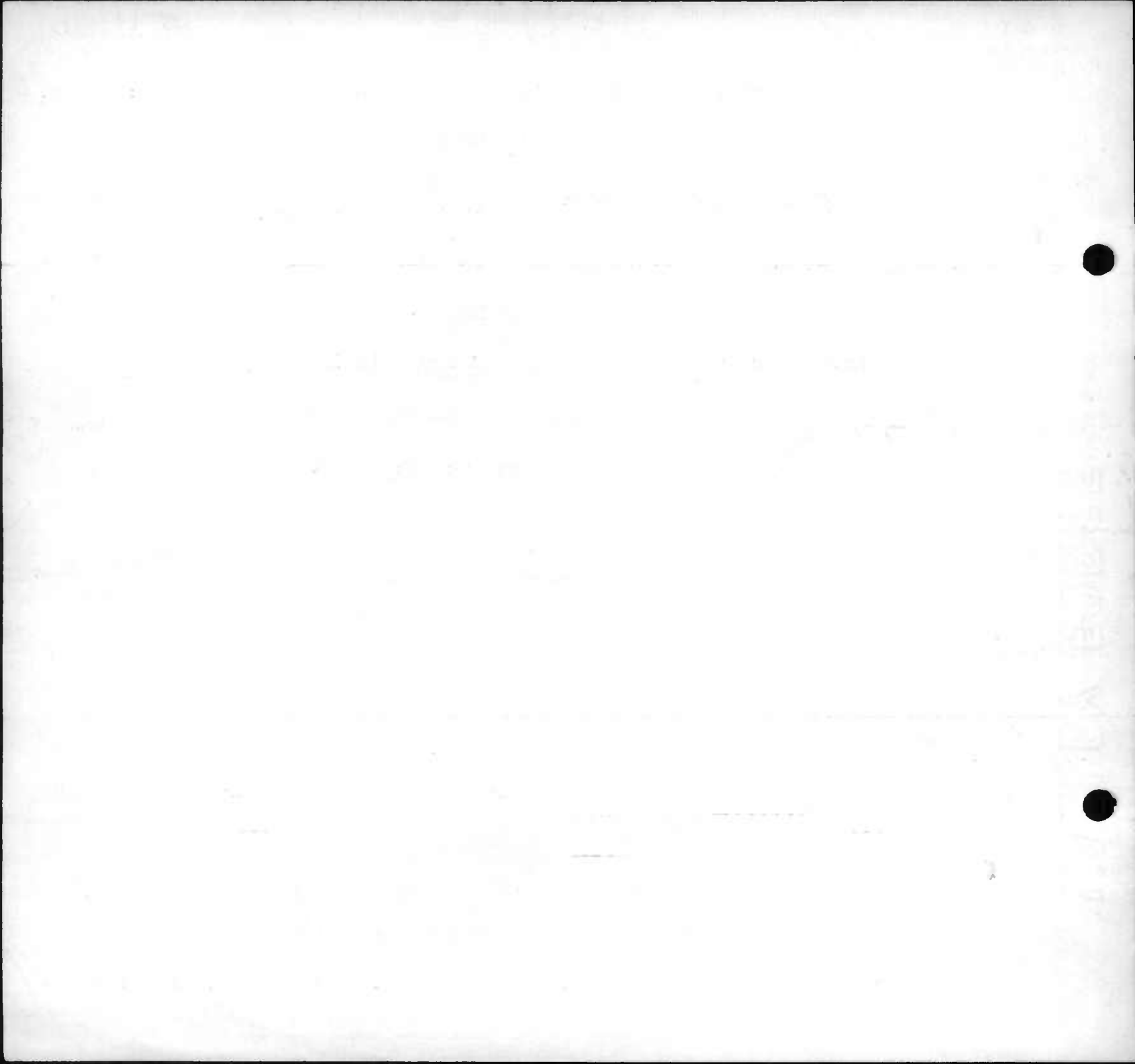
67 11159		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11159	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>George H. Gosman</u>				<u>16 Nov 1967</u> <u>2:45 P.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University of Maryland Hosp.</u>		A. STATE <u>Maryland</u> B. COUNTY <u>A-H-C</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Severna Park</u> <u>52-00</u>			
		D. STREET ADDRESS (If rural, give location) <u>PO Box 595 Severna Park</u>			
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>28 June 1914</u>	9. AGE (In years last birthday) <u>52</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocery Proprietor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Foodland</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George John Gosman</u>		14. MOTHER'S MAIDEN NAME <u>Edith HANSON</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown; if yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216072962</u>		17. INFORMANT ADDRESS <u>Evelyn Gosman (wife)</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>163X I Pulmonary Insufficiency</u>		(A) DUE TO <u>Ca of 2 lung requiring</u>		(B) DUE TO <u>a 2 pneumorectomy</u>	
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>II</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7 Oct 1967</u> 19 to <u>16 Nov 1967</u> that (I) (we) last saw the deceased alive on <u>16 Nov 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Santos, Ch. S.</u>				23B. DATE SIGNED <u>16 Nov 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>Defin S. Santos</u>				23D. ADDRESS <u>University of Md. Hosp</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-20-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven Cem</u>	
24D. LOCATION (City, town, or county) (State) <u>Glen Burnie</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 21 1967</u>		25B. NAME OF REGISTRAR <u>Robert S. Barra</u>	
25C. FUNERAL DIRECTOR <u>Robert S. Barra</u>		25D. ADDRESS <u>Severna Park</u>			



# FUNERAL DIRECTOR: IMPORTANT

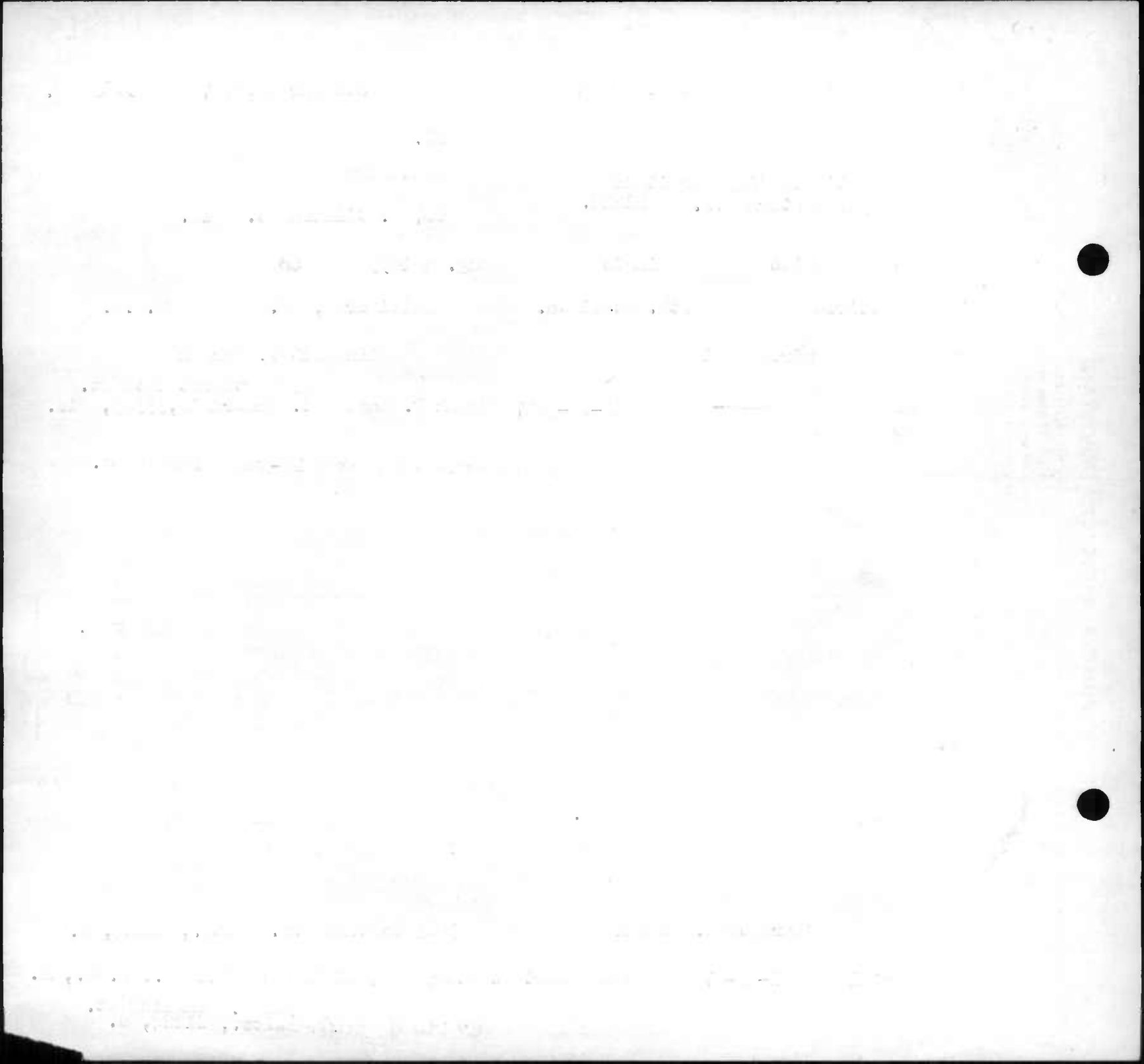
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 11160</u>	
BIRTH NO. <u>7-650</u> <u>67-08406</u>		67 11160		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Torain, Baby of Cheryl Boy		4-26-67 5:10 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <u>33 The Johns Hopkins Hospital</u>		A. STATE Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give town) <u>15-06</u> Baltimore			
		D. STREET ADDRESS (If rural, give location) 1702 Braddish Ave.			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) new born	8. DATE OF BIRTH 4-26-67	9. AGE (In years last birthday) New born	10. CITIZEN OF WHAT COUNTRY 8
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Raymond Torain		14. MOTHER'S MAIDEN NAME Cheryl Williams			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Prematurity DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-26</u> <u>19 67</u> to <u>4-26</u> <u>1967</u> , that (I) (we) lost saw the deceased alive on <u>4-26</u> <u>19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>G. A. Glowacki</u> M.D.				23B. DATE SIGNED <u>11/13/67</u>	
23C. PHYSICIAN'S NAME (Type) Gerald A. Glowacki				23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 4/28/67		24C. NAME OF CEMETERY or CREMATORY The Johns Hopkins Hosp.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 21 1967		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR ADDRESS HOSPITAL DISPOSAL					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 11161	
BIRTH NO. 67 11161		CERTIFICATE OF DEATH		67 11161	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EWALD G. SAAL		2. DATE AND HOUR OF DEATH November 19, 1967 9:15 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26-71	
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Ave. # 21224.		D. STREET ADDRESS (If rural, give location) 607 S. Clinton St. # 24.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Aug. 1899	9. AGE (In years last birthday) 68	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Andrew Saal		14. MOTHER'S MAIDEN NAME Elizabeth V. Dorman	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-9227		17. INFORMANT 809 NorthEast 20th St. Frank P. Saal Ft. Lauderdale, 33305, Fla.	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardio-vascular Disease DUE TO		CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Gout				15 yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 19 53 to November 19 67, that (I) (we) last saw the deceased alive on Oct. 28 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Clarence W. LeDoux M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/20/67	
23C. PHYSICIAN'S NAME (Type) Clarence W. LeDoux M.D.		23D. ADDRESS 3023 Eastern Ave. Balto., 21224, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-22-67		24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetery	
24D. LOCATION (City, town, or county) (State) 7401 German Hill Rd., Ba. Co., Md.					
25A. DATE REC'D. BY HEALTH DEPT. NOV 21 1967		25B. NAME OF REGISTRAR Robert E. Taney M.D.		25C. FUNERAL DIRECTOR Charles J. Seiler Balto., 21224, Md.	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-363		67 11162		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11162	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>KATIE STEWART</b>			
2. DATE AND HOUR OF DEATH <b>11/19/67</b>				2. DATE AND HOUR OF DEATH <b>220 P. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE 21224, MARYLAND</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
D. STREET ADDRESS (If rural, give location) <b>3237 BURLEIGH AVE.</b> <b>21215</b>				15-05			
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b> (specify)	8. DATE OF BIRTH <b>5-1-00</b>	9. AGE (In years last birthday) <b>67</b>	10. Under 1 Yr. Months: Days	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>NED NOLAN</b>				14. MOTHER'S MAIDEN NAME <b>KATE NOLAN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>RECORDS: BCH 4940 EASTERN AVE. BALTO. 21224,</b>		ADDRESS <b>MD.</b>	
18. <b>330X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>? reason - cardiorespiratory arrest</b>				CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>subarachnoid bleed; dementia ~10 days</b> DUE TO			
(C) <b>polycystic kidneys, liver.</b> DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>yes - congenital</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11/8/67</b> 19 <b>67</b> to <b>11/19</b> 19 <b>67</b> , that (I) <b>we</b> last saw the deceased alive on <b>11/19</b> 19 <b>67</b> and that in (my) <b>our</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>we</b> (did) (did not) view the body after death.							
23A. SIGNATURE <b>Paul E. Michelson</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/19/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. PAUL E. MICHELSON</b>				23D. ADDRESS <b>BALTIMORE 21224, MARYLAND</b> <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11-22-67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>NEW CATHARAL Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 21 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Nelson Funeral Home 1348 Calhoun St.</b>			

20-10-1910

10-10-1910

10-10-1910

10-10-1910

10-10-1910

10-10-1910

X

10-10-1910

10-10-1910

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD

November 16, 1967 1:00 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1715 Latrobe Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1715 Latrobe Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Nov. 15, 1892

9. AGE (In years  
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Williams

14. MOTHER'S MAIDEN NAME

Mary Burrell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

214-14-7378A

17. INFORMANT

ADDRESS

Mrs. Annie Williams

1715 Latrobe St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 16, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

23B. DATE

11-20-67

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cemetery

23D. LOCATION

(City, town, or county)

New Kent Co. Virginia

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 21 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Arlington S. Phillips 1727 N. Monroe St.

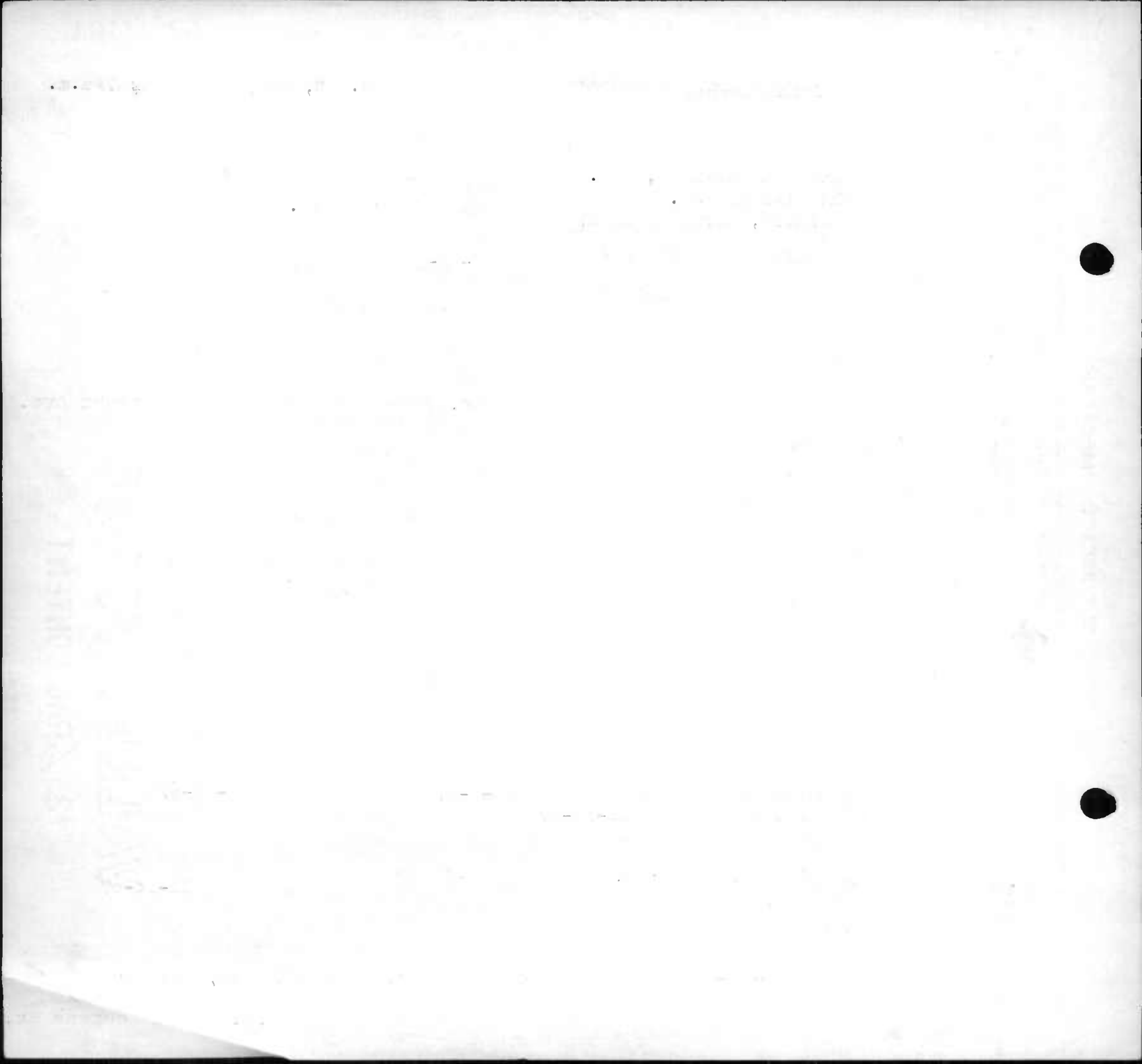
ADDRESS

Chit 2.2.10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11164</b>
BIRTH NO. <b>67 11164</b>		<b>CERTIFICATE OF DEATH</b>		
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <b>Nov. 18, 1967 / 8:27 a.m. / M.</b>		
1. NAME OF DECEASED (Type or Print) <b>Viola Johnson</b>				
3. PLACE OF DEATH <b>IN BALTIMORE, MARYLAND</b>		4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital, Inc. 1514 Division St. Baltimore, Maryland 21217</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
39		D. STREET ADDRESS (If rural, give location) <b>2303 Garrett Ave.</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>5-30-32</b>	9. AGE (In years last birthday) <b>35</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
13. FATHER'S NAME <b>WADE LIGHTNER</b>		14. MOTHER'S MAIDEN NAME <b>ALBERTA LIGHTNER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mr. Joseph Johnson 2303 Garrett Ave.</b>	
18. <b>170 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Metastatic carcinoma of the lungs from carcinoma of right breast.</b>		INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>10-9-67</b> 19 to <b>11-18-67</b> 19, that (I) (we) last saw the deceased alive on <b>11-18-67</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Swardi Setasuban</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>11-18-67</b>
23C. PHYSICIAN'S NAME (Type) <b>SWASDI SETASUBAN</b> M.D.			23D. ADDRESS <b>PROVIDENT HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>11-22-67</b>	24C. NAME OF CEMETERY or CREMATORY <b>BALTIMORE NATIONAL CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 21 1967</b>		25B. NAME OF REGISTRAR <b>R. E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>MORTON &amp; DYETT F.H. 1701 Laurens St.</b>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>67 11165</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>67 11165</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<b>OPHELIA CROCKETT</b>		<b>11-19-67</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE <b>MARYLAND</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		
D. STREET ADDRESS (If rural, give location) <b>2003 N. Bentalou Street</b>			D. STREET ADDRESS (If rural, give location) <b>2003 N. Bentalou Street</b>		
5. SEX <b>F.</b>	6. RACE <b>N.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>Jan 14, 1902</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>HICKORY GROVE, S.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>JAMES ROBINS</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Robert Hoyle</b>
					ADDRESS <b>2003 N. Bentalou St.</b>
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <b>Cerebral Thrombosis</b> DUE TO		
			(B) <b>Arteriosclerotic C.V. Disease</b> DUE TO		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<b>Chr. Brain Syndrome</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 19 1919</b> to <b>Nov 19 1967</b> , that (I) <del>was</del> last saw the deceased alive on <b>Nov 17 1967</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>did not</del> view the body after death.					
23A. SIGNATURE <b>H. Garland Chissell Jr.</b>				23B. DATE SIGNED <b>11-20-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>H. Garland Chissell Jr.</b>				23D. ADDRESS <b>1038 Edmondson Ave Baltimore Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11-22-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>MOUNT CALVARY CEM.</b>	
				24D. LOCATION (City, town, or county) (State) <b>A.A.CO., MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 21 1967</b>		25B. NAME OF REGISTRAR <b>Robert S. Feltz</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>	
				ADDRESS <b>1701 Laurens St.</b>	





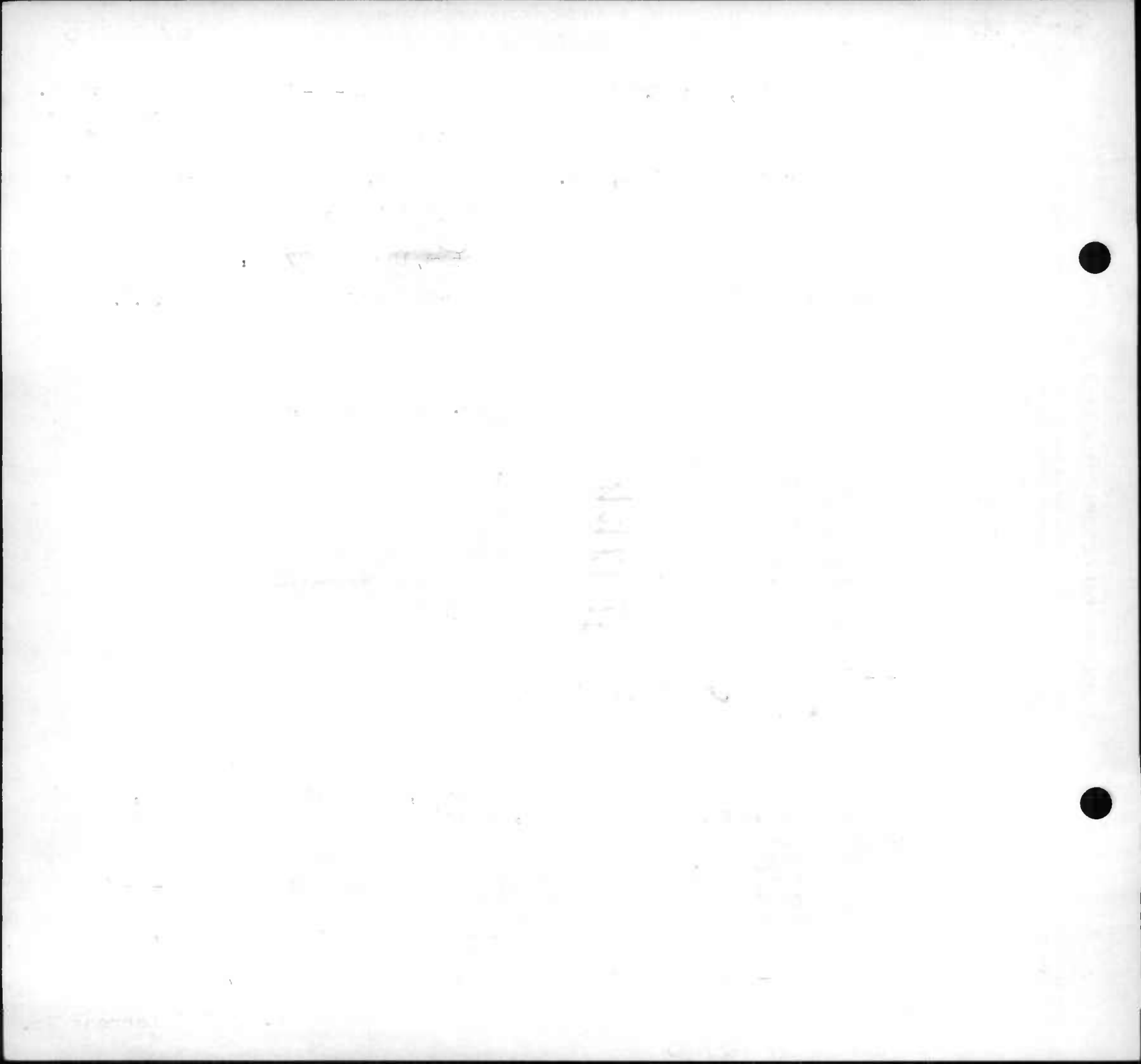
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11166

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 67 11166

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Smith, Mary Spady		11-20-67 5:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Provident Hospital, Inc.				Maryland			
				C. CITY OR TOWN (If outside city limits, write FULL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				3915 Hilton Road			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
F	N			Sept 9, 1890	77 yrs.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired				North Carolina		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
ABE MAJETT				UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				Mr. Johnnie Cotton, -Son		SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
493 X 1 E 904.0				Maxine Pulmonary Embolism with Pneumonia R.L.L.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(A) DUE TO (B) DUE TO (C) DUE TO			
				Post hip prosthesis for fx neck femur d) Sensibility			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Sensibility			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
11-8-67		Application of Austin-Moore Hip Prosthesis		Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
		Hallway		Home 3915 Hilton Rd			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
10-23-67 6:00 AM				Fell down.			
22. I certify that (I) (this hospital) attended the deceased from October 30, 1967 to November 20, 1967, that (I) (we) last saw the deceased alive on November 20, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
P. Chotikul M.D.				11-20-67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
POCHNA CHOTIKUL M.D.				1514 Division Street Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		11-25-67		MOUNT AUBURN CEM.		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 21 1967		Robert E. Jenkins		MORTON & DYETT F.H.		1701 Laurens St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11167		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 11167	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Andreas Ratawecki</b>		2. DATE AND HOUR OF DEATH <b>11-16-67 120 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>ANDREAS RASTAWECKI</b> FULL NAME OF (If not in hospital or institution, give street address or location) <b>HOSPITAL OR INSTITUTION</b> <b>P-DR.S. MORRISON</b> <b>35 Church Home Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>107 N. Lakewood Ave</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>3-26-02</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. If Under 24 Hrs. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Veterinarian</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Austria</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>John Ratawecki</b>		14. MOTHER'S MAIDEN NAME <b>Adolphine Koeppe</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-38-3807</b>		17. INFORMANT <b>Mrs. Sophia Rastawiecki 107 N. Lakewood Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>162.1 I</b> <b>Branchogenic carcinoma 17 mos of lung</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>June 1966</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of lung</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (his hospital) attended the deceased from <b>9-30 1967</b> to <b>11-16 1967</b> , that (I) (we) last saw the deceased alive on <b>11-16 1967</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.					
23A. SIGNATURE <b>Rodelio M. Jim</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-16-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Rodelio M. Jim</b>		M.D. ADDRESS <b>CHH</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Nov 20, 1967</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Michael Ukrainian</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 21 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Tarkenton</b>		25C. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc. F. H. 1901 Eastern Ave.</b>	

11-10-67

413

BALTIMORE

207 N. Lakewood Ave

3-26-62

MARRIED W M

Austria

Veterinarian

Adolphine Kocypc

John Ratnwick

214 38 38

No

of lung  
Bronchogenic carcinoma 17 yrs

June 1966 carcinoma of lung No

11-10-67

CO

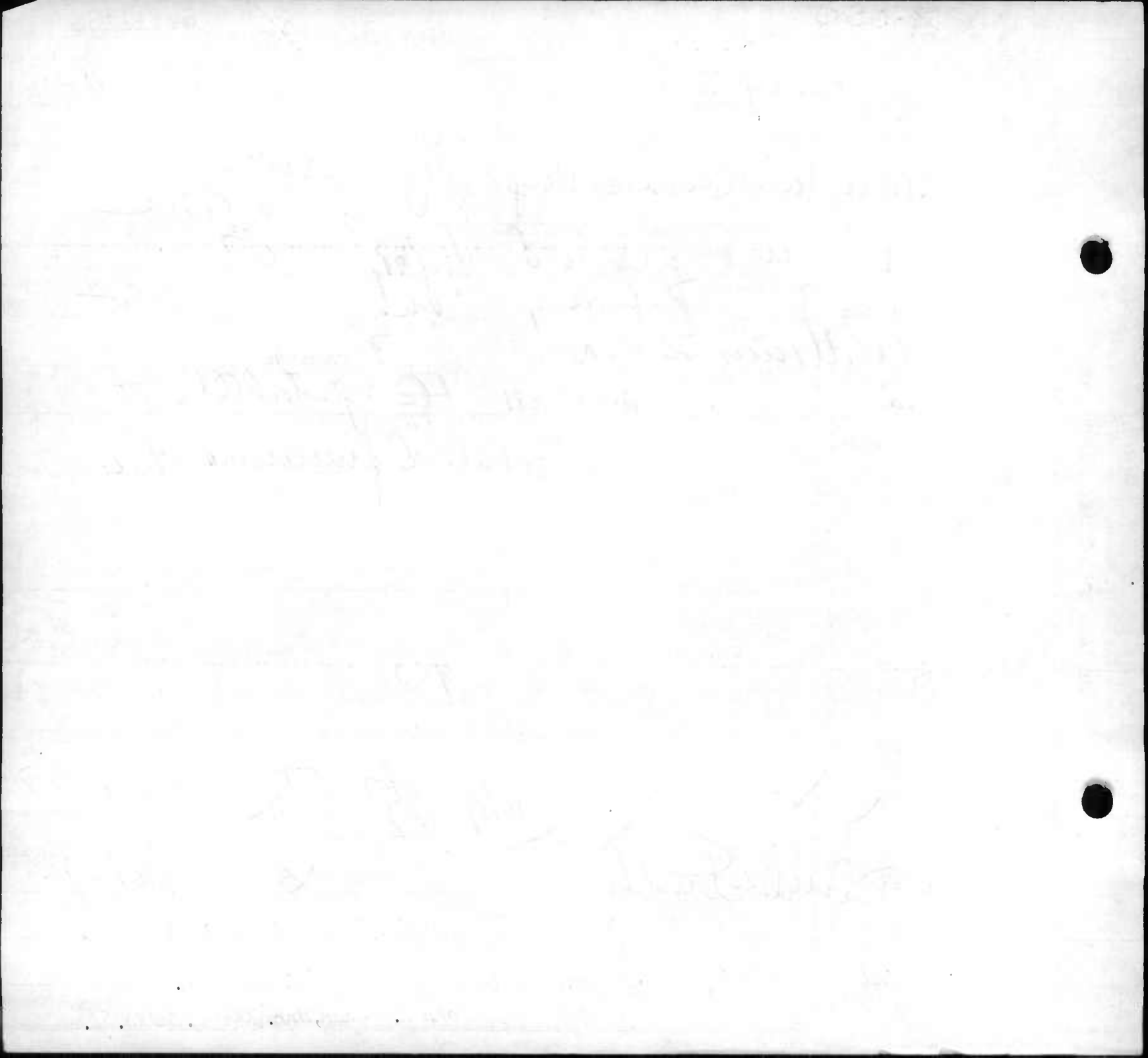
Bochalis M. J. M.  
Kochalis M. J. M.

CHM

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11168</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>Z-650</b></span> <span><b>67 11168</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <b>1</b></span> <span>M.E. CASE NO. <b>67 11168</b></span> </div>					
1. NAME OF DECEASED (Type or Print) <b>Kenny Zorn</b>			2. DATE AND HOUR OF DEATH <b>11/19/67 11 AM.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Klam Land General Hosp</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Cecil</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>5200</b> D. STREET ADDRESS (If rural, give location) <b>8 Virginia Ave</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>11/19/1899</b>	9. AGE (In years, last birthday) <b>67</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Refinery</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>			13. FATHER'S NAME <b>William Zorn</b>		
14. MOTHER'S MAIDEN NAME <b>? unknown</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO. <b>215071081</b>			17. INFORMANT <b>Hospital Chart</b> ADDRESS <b>Hospital Chart</b>		
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p><b>I</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>Bilateral pneumonia</b></p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><b>4 days</b></p> </div> </div>					
<p><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/19/67</b> to <b>11/19/67</b> that (I) (we) last saw the deceased alive on <b>11/19/67</b> and that in (my) (our) opinion death occurred on the date <b>11/19/67</b> and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Daniel Lindenstruth</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>11/20/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>DANIEL LINDENSTRUTH</b>				23D. ADDRESS <b>Maryland General Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/22/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore</b>		24E. (State) <b>Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 21 1967</b>	
25B. NAME OF REGISTRAR <b>Robert E. Fairley</b>		25C. FUNERAL DIRECTOR <b>John A. Moran, Inc. 3000 E. Balto. St.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-530		67 11169		BALTIMORE CITY HEALTH DEPARTMENT		67 11169	
BIRTH NO.		M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <b>BENNETT, HARRY</b>				2. DATE AND HOUR OF DEATH <b>11/16/67 15<sup>38</sup> PM</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL 42</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore Md. 15-38</b> D. STREET ADDRESS (If rural, give location) <b>8414 Forest Park Ave.</b>			
5. SEX <b>M</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>10-21-82</b>	9. AGE (In years last birthday) <b>85</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Gabriel Bennett</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Mayson</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Charles Bennett 1626 W. Fayette</b>			
18. <b>327.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Chronic obstructive lung disease</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Dehydration &amp; malnutrition, anemia</b>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11/16/67</b> 19 to <b>11/16</b> 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>11/16/67</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Kenneth Wetcher</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/16/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>KENNETH WETCHER</b> M.D.				23D. ADDRESS <b>Sinai Hosp</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-26-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 21 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>W.C. Muehl</b>		ADDRESS <b>928 E. North</b>	

10-25-01

10-25-01



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>7-618</b> <b>67 11170</b>		BALTIMORE CITY HEALTH DEPT. <b>CERTIFICATE OF DEATH</b>		Registered No. <b>67 11170</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<b>TRABERT GERTRUDE ANNA</b>		<b>NOVEMBER 20 1967</b> <b>8:55 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST AGNES HOSPITAL</b>			A. STATE <b>MD</b> B. COUNTY <b>20-05</b>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		
			D. STREET ADDRESS (If rural, give location) <b>613 S BENTALOU ST.</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>Wh</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>7-2-95</b>	9. AGE (In years lost birthday) <b>72</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>LOUIS</b>			14. MOTHER'S MAIDEN NAME <b>ANNA SERBE</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215 07 6911</b>	17. INFORMANT ADDRESS <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVE.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>260 X I</b> (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Diabetic acidosis</b>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO <b>Electrolyte imbalance</b>		
			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>OCT 14 1967</b> to <b>NOV 20 1967</b> , that (I) (we) lost saw the deceased alive on <b>NOV 20 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Steve C. Papastefanous</b>				23B. DATE SIGNED <b>11-20-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Steve C. Papastefanous</b>				23D. ADDRESS <b>CATON &amp; WILKENS AVE. BALTIMORE MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/24/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Druid Ridge Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 21 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairman</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Witzke F. D. - 4101 Edmondson AVE.</b>	

EXHIBIT

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11171		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11171	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				Mary B. Dillon	
2. DATE AND HOUR OF DEATH		11-18-67 6:45AM.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
<b>CERTIFICATE AMENDED</b> (If not in hospital or institution, give street address or location) 12-1-67 40 St. Agnes Hospital Caton and Wilkens Avenue Baltimore, Maryland 21229		A. STATE Maryland B. COUNTY Linthicum (21090) 5200			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) 201 Nursery Road			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days
Female	White	Widowed	8-28-1886	83 84 83 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Emmitsberg, Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Sebastian Florence			Anna Eckenrode		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		217-38-4897		Joseph Dillon 201 Nursery Rd. Linth. Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.)		Carcinoma of uterus			
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Similarity and Anterior Pelvic	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Jan 15/64 19 to Nov 18/67 1967, that (I) (we) last saw the deceased alive on Nov 18/67 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
M. Paul Byerly					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
M. Paul Byerly				5520 York Rd Balto Md 21212	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/21/67		New Cathedral Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 21 1967		Robert E. Fisher		Wm. Cook-Brooks Inc. Baltimore, Md. 21202	

Baptismal Record and V.S. 153  
12-1-67 M.H.

SAB-47-89-82

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

67 11172

BIRTH NO.

67 11172

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

KNORR, Elorse M.

2. DATE AND HOUR OF DEATH

11-14-67 7:40 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

7828 James Ford Road 21222

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

12-15-1900

9. AGE (In years  
last birthday)

66

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

New Jersey

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Bubbs

14. MOTHER'S MAIDEN NAME

~~Wolke~~ Eliza Wolfkeil

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-26-2436

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18. 331 X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury at complication which caused death.)

(A) RESPIRATORY FAILURE

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) MASSIVE BRAINSTEM CVA.

DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

None

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

None

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

None

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

None

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

None

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

None

21D. TIME OF INJURY (APPROX.)

None

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

None

22. I certify that (I) (this hospital) attended the deceased from 11-12 1967 to 11-14 1967 that (I) (we) last saw the deceased alive on 11-14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

P. Desmond

M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

11-14-67

23C. PHYSICIAN'S NAME (Type)

P. Desmond

23D. ADDRESS

M.D. 4940 Eastern Avenue, Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/17/67

24C. NAME OF CEMETERY or CREMATORY

Baltimore National

24D. LOCATION (City, town, or county) (State)

Catonsville, Md.

25A. DATE REC'D BY HEALTH DEPT.

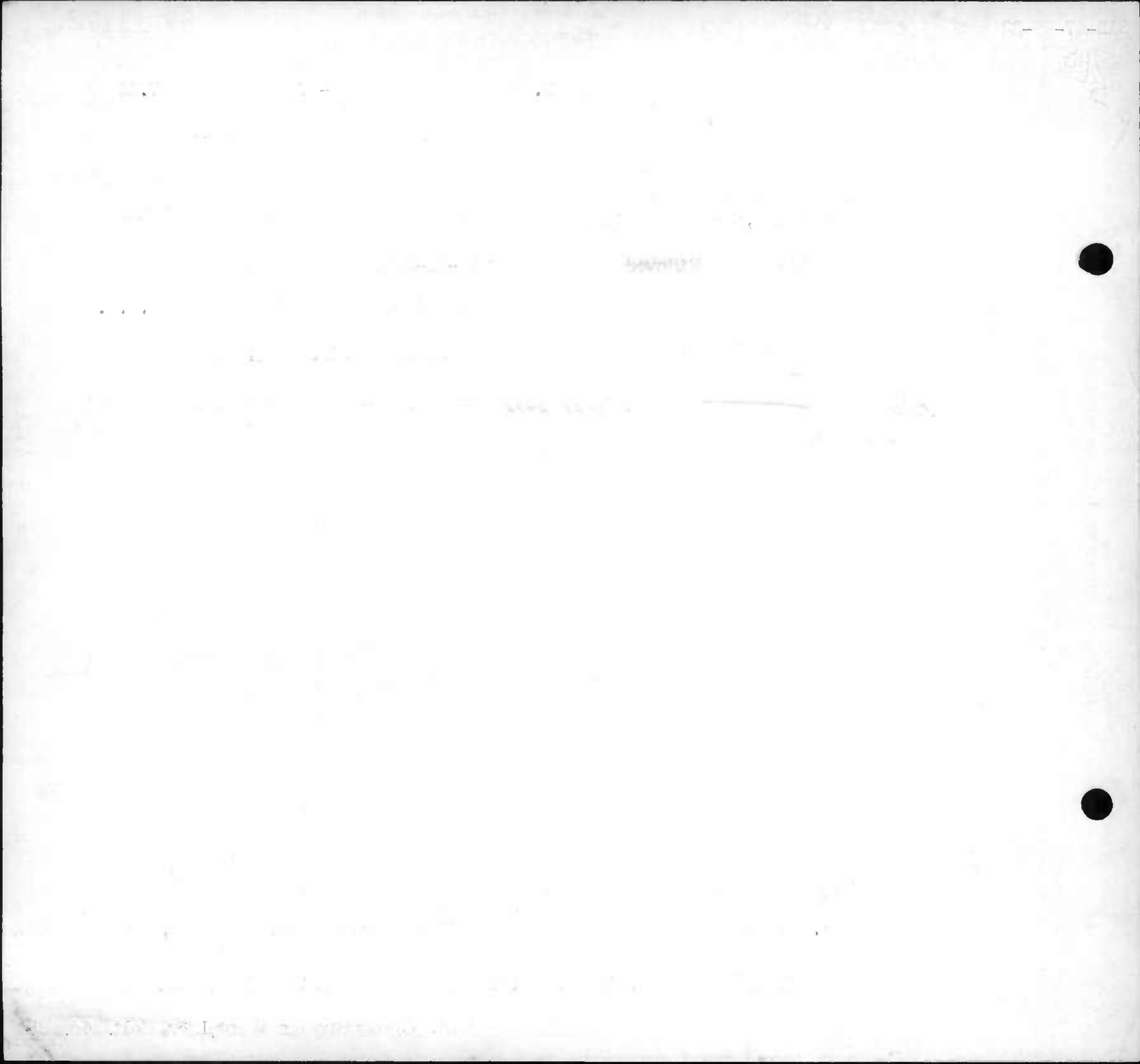
NOV 21 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

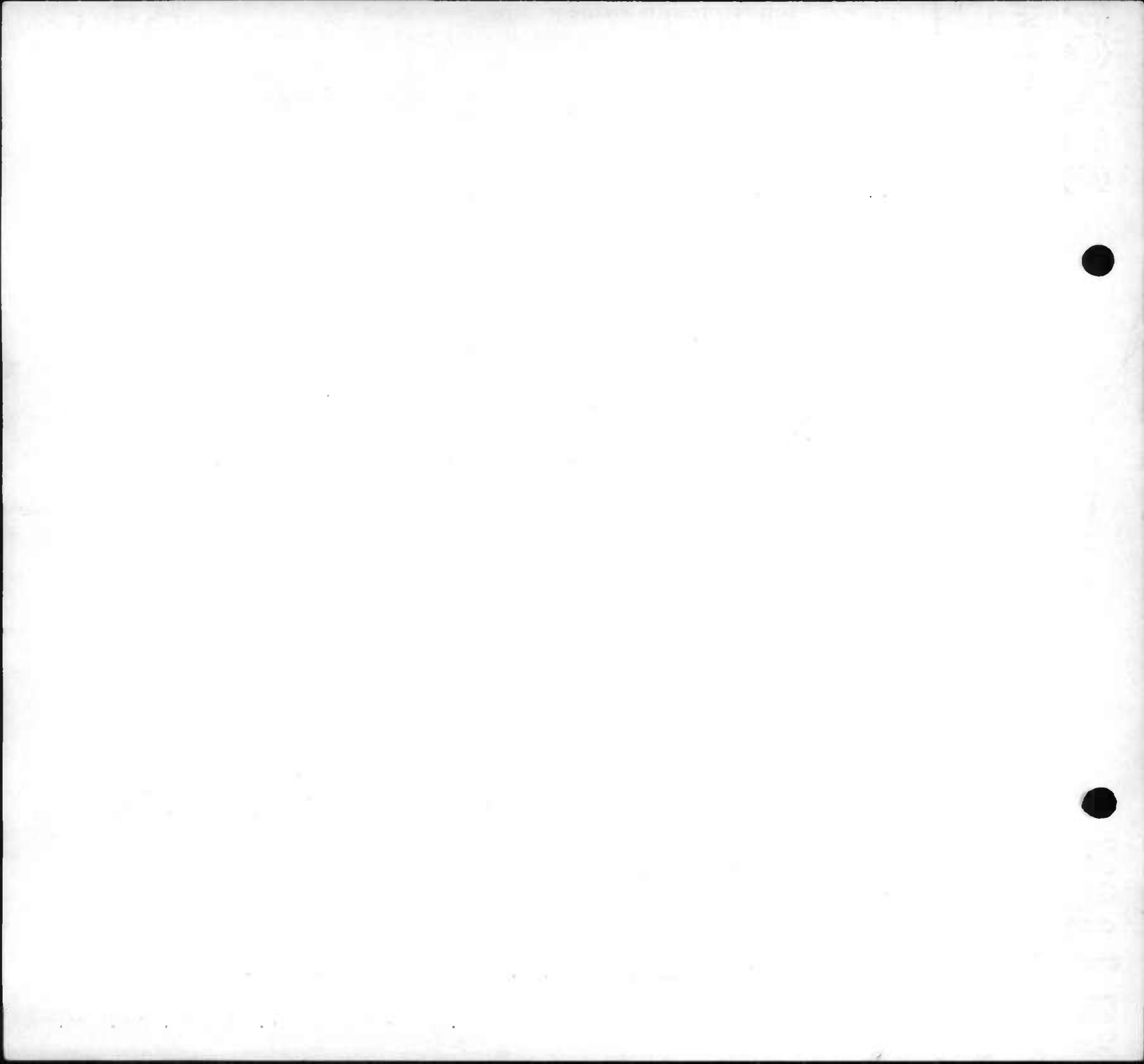
Wm. Cook-Brooks West Inc. Balt. Md. 28



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>67 11173</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>67 11173</b>	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>Michael Sabia</b>			2. DATE AND HOUR OF DEATH <b>11/20/67 1:03 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>11-03</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hospital</b> (If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
D. STREET ADDRESS (If rural, give location) <b>3000 W. Franklin St.</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Never married</b>	8. DATE OF BIRTH <b>2/10/30</b>	9. AGE (In years last birthday) <b>37</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>waiter</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13. FATHER'S NAME <b>Michael S. Sabia</b>			14. MOTHER'S MAIDEN NAME <b>Ann Marcisofsky</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>207-241-6171</b>	17. INFORMANT ADDRESS <b>Hospital Chart</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>034X</b> <b>Bacterial Endocarditis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b>		
<p style="text-align: center;"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/20 1967</b> to <b>11/20 1967</b> , that (I) (we) last saw the deceased alive on <b>11/20 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Daniel Lindenstruth</b> M.D.			23B. DATE SIGNED <b>11/20/67</b>		
23C. PHYSICIAN'S NAME (Type) <b>DANIEL LINDENSTRUTH</b> M.D.			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>11/20/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Fitzpatrick F. H.</b>	
24D. LOCATION (City, town, or county) (State) <b>Abington, Pa.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 21 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks, Inc. 1217 St. Paul St.</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

67 11174

CERTIFICATE OF DEATH

Registered No. 67 11174

BIRTH NO. 67 11174

M.E. CASE NO. 67 11174

1. NAME OF DECEASED (Type or Print) SIMMONS, BONNIE

2. DATE AND HOUR OF DEATH 11/17/67 6:35 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE NORTH CAROLINA

C. CITY OR TOWN (If outside city limits, write RURAL and give township) OLD FORT

D. STREET ADDRESS (If rural, give location) BOX 388

5. SEX FEMALE

6. RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED

8. DATE OF BIRTH 9-4-20

9. AGE (In years lost birthday) 47

If Under 1 Yr. Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME WILEY DAVIS

14. MOTHER'S MAIDEN NAME POLLY LYTLE LYTLE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT Westmead-Hawkins F.H.

ADDRESS Marion N.C.

18. 202.1 CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH LYMPHOMA

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES (b) with PNEUMONIA.

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED While At ☐ Not While At ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct. 27 19 67 to Nov 17 19 67, that (I) (we) last saw the deceased alive on Nov 17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Jack Brandes M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED 11/17/67

23C. PHYSICIAN'S NAME (Type) JACK BRANDES M.D.

23D. ADDRESS JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify) Removal

24B. DATE 11/17/1967

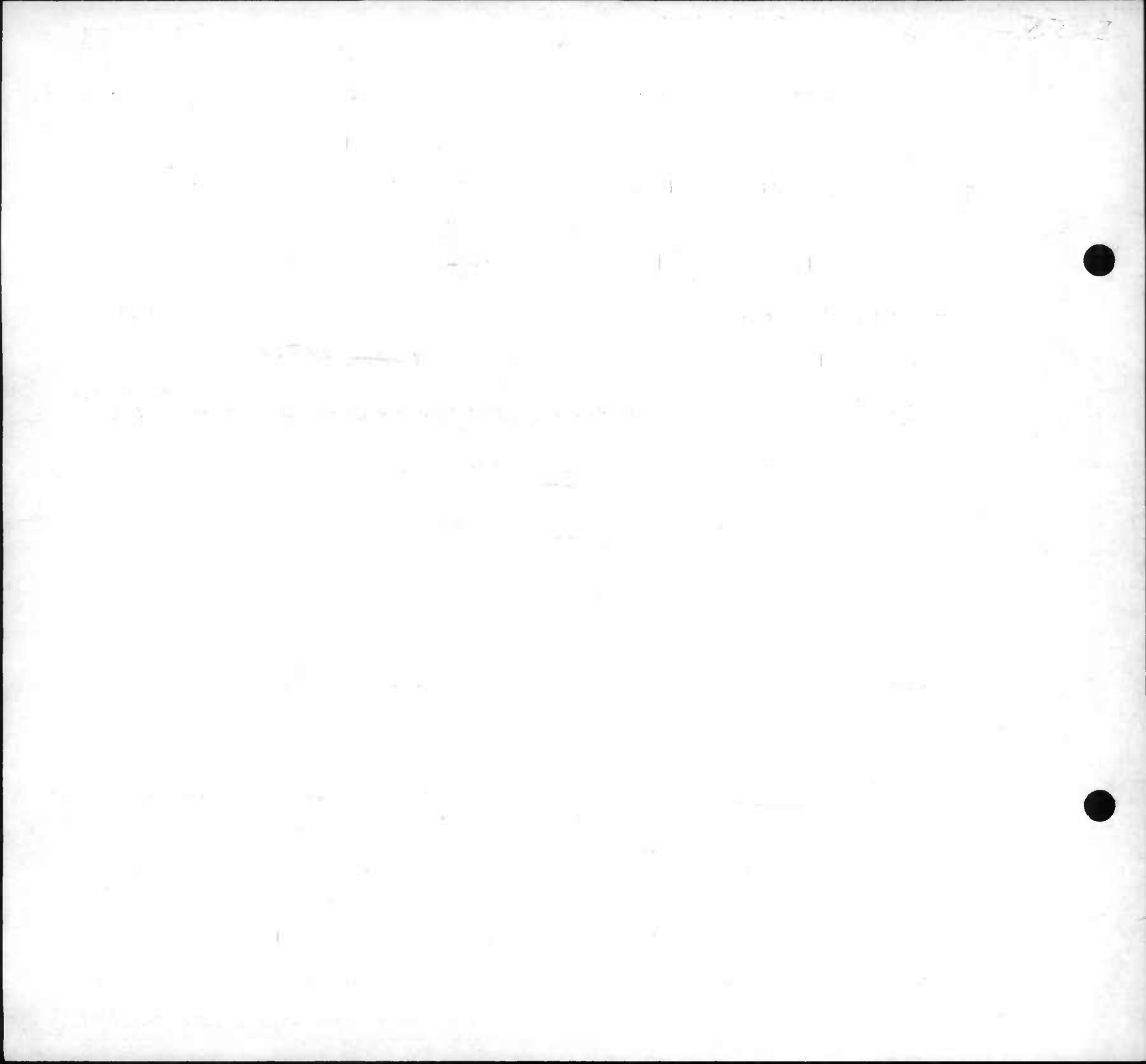
24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State) Marion, North Carolina

25A. DATE REC'D BY HEALTH DEPT. NOV 21 1967

25B. NAME OF REGISTRAR Robert E. Taylor

25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc., Balto., Md



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11175</b>	
BIRTH NO. <b>67 11175</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Lillian Oliver</b>		2. DATE AND HOUR OF DEATH <b>11/19/67</b> <b>6<sup>15</sup> P.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b> <b>38</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>19-01</b> D. STREET ADDRESS (If rural, give location) <b>1611 W. Molberry</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>W</b>	8. DATE OF BIRTH <b>10/15/09</b>	9. AGE (In years last birthday) <b>58</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JACOB SMITH</b>		14. MOTHER'S MAIDEN NAME <b>Louise</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Patricia M. 2911 Princeton St</b>	
18. <b>175.0 I</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Ovarian Carcinoma</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/19</b> 19 <b>67</b> to <b>11/19</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11/19</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Hudson Fesche</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11/19/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Hudson Fesche</b>		23D. ADDRESS <b>University Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/24/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn</b>	
24D. LOCATION (City, town, or county) <b>Baltimore</b>		(State)			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 21 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Fesche</b>		25C. FUNERAL DIRECTOR <b>Marshall P. Ayers</b>	
				ADDRESS <b>38 N. Gilman</b>	

1870

1871

1872


1873

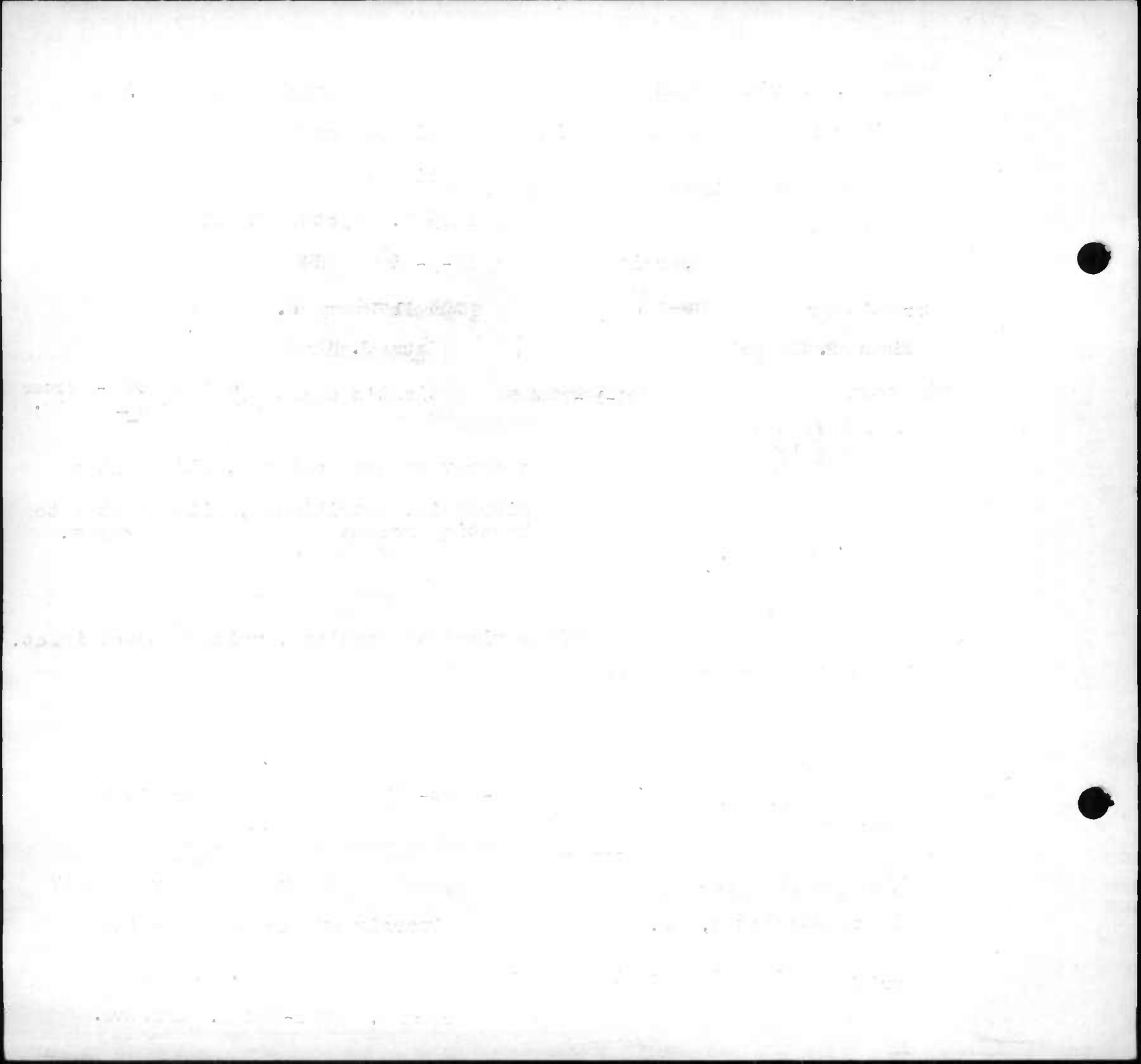
1874

1875

1876

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11176</b>	
BIRTH NO. <b>67 11176</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Hammond, Calvin Thomas</b>		2. DATE AND HOUR OF DEATH <b>16 November 1967   4:00 P M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  <b>University of Maryland Hospital</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Lombard &amp; Green Streets</b> <b>38</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Baltimore Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL, and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1105 E. Fayette Street</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>10-5-09</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gar Cleaner</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>		11. BIRTHPLACE (State or foreign country) <b>Carroll County Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Simon P. Hammond</b>		14. MOTHER'S MAIDEN NAME <b>Laura J. Dorsey</b>	
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) <b>Not known</b>		16. SOCIAL SECURITY NO. <b>171-18-7044</b>		17. INFORMANT <b>patient's chart Naomi Hammond - 1 Mercer Ellicott, City - Ave.</b>	
18. <b>581.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebrovascular Accident, old months</b>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cirrhosis, nutritional, with months to hepatic precoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years.</b>	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>possible visceral neoplasm, urinary tract infct.</b>					
19A. DATE OF OPERATION <b>7 Nov 67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>removal cyst</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from <b>11-1st-67</b> 19 to <b>16 Nov 1967</b> 19, that (I) (we) last saw the deceased alive on <b>16 Nov 1967</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>nov 16 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>Stanley Stapleton, Jr.</b>		23D. ADDRESS M.D. <b>University of Maryland Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/20/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 21 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>	
25C. FUNERAL DIRECTOR <b>Herbert E. Nutter-3035 W. North Ave.</b>		25D. ADDRESS <b>Herbert E. Nutter-3035 W. North Ave.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**  
Registered No. **67 11177**

BIRTH NO. **67 11177**

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

**Harry L. Robinson**

2. DATE AND HOUR OF DEATH

**November 20, 1967**

**2:30 AM**

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(If not in hospital or institution, give street  
address or location)

**00**

**200 Woodlawn Road**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

**Maryland**

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

**Baltimore**

D. STREET ADDRESS (If rural, give location)

**200 Woodlawn Road**

5. SEX

**M**

6. RACE

**W**

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

**Widowed**

8. DATE OF BIRTH

**8/11/1895**

9. AGE (In years  
last birthday)

**71**

If Under 1 Yr.  
Months Days

If Under 24 Hrs.  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

**Vice-President**

10B. KIND OF BUSINESS OR INDUSTRY

**Robb Tyler, Inc.**

11. BIRTHPLACE (State or foreign country)

**Baltimore, Maryland**

12. CITIZEN OF  
WHAT COUNTRY?

**U. S. A.**

13. FATHER'S NAME

**Wilbert Robinson**

14. MOTHER'S MAIDEN NAME

**Mary O'Rourke**

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

**Yes**

**WWI**

16. SOCIAL  
SECURITY NO.

**216-01-3856**

17. INFORMANT

ADDRESS

**Mrs. Mary Frances Wilson, 200 Woodlawn Road**

18. **177X 1260X**  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION (s).

CAUSE OF DEATH

(A) **Carcinomatosis - prostate**  
DUE TO

(B)  
DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

**5 years**

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

**arteriosclerosis - Diabetes  
abdominal aneurysm**

**5 years**

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐

Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from **11-5-67** to **11-20-67**,  
that (I) (we) last saw the deceased alive on **11-19-67** and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

**Franklin E. Leslie**

M.D.

Attending  
Phys. ☒

Med.  
Director ☐

Staff  
Phys. ☐

23B. DATE SIGNED

**11-20-67**

23C. PHYSICIAN'S  
NAME (Type)

**Franklin E. Leslie**

M.D.

23D. ADDRESS

**302 E. 33rd St.**

24A. BURIAL CREMATION,  
REMOVAL (Specify)

**Burial**

24B. DATE

**11/22/67**

24C. NAME of CEMETERY or CREMATORY

**New Cathedral**

24D. LOCATION

**Baltimore,**

(City, town, or county)

(State)

**Maryland**

25A. DATE REC'D BY HEALTH DEPT.

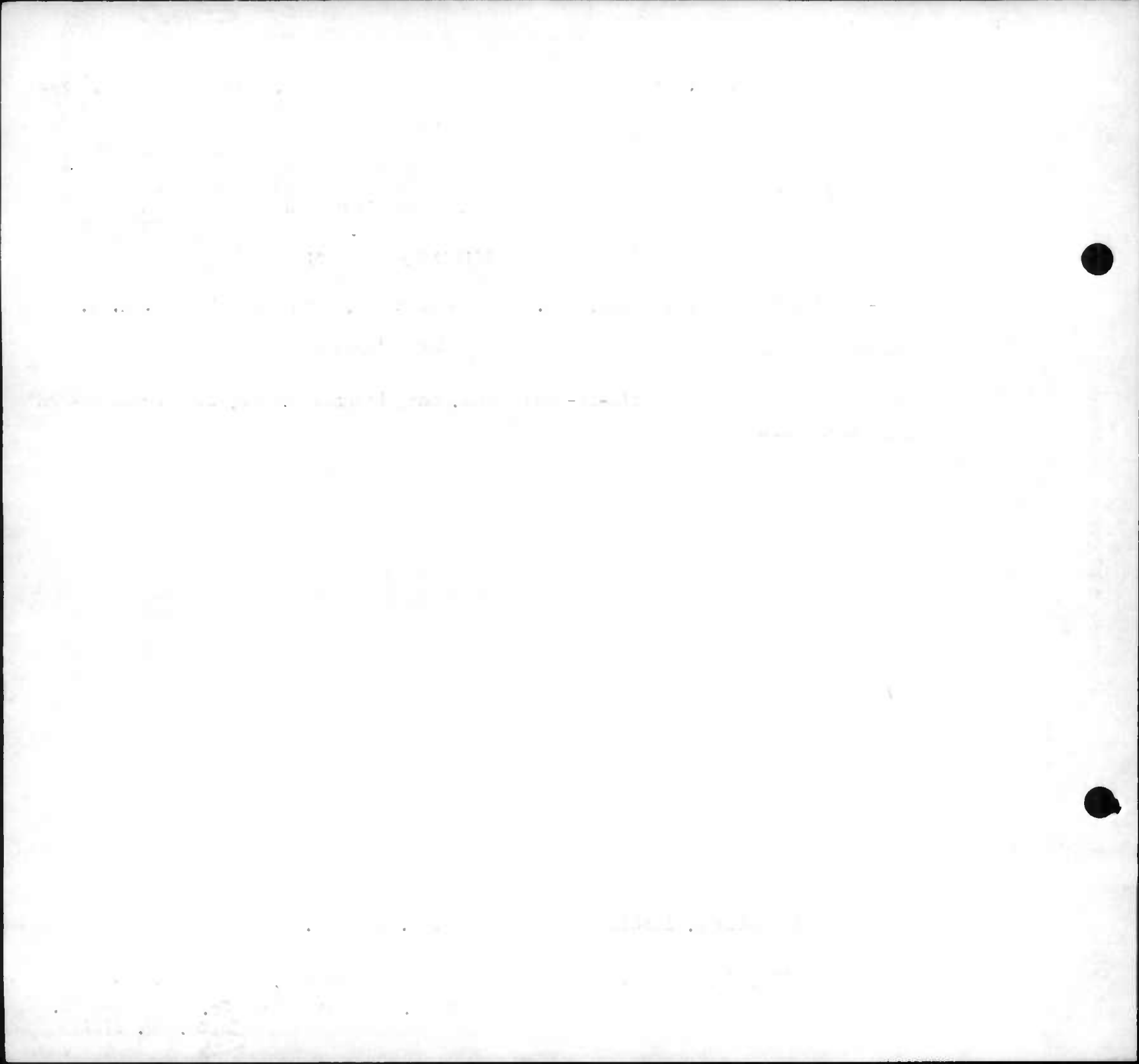
**NOV 22 1967**

25B. NAME OF REGISTRAR

**Robert E. Jenkins**

25C. FUNERAL DIRECTOR,

**Henry W. Jenkins & Sons Co. 4905 York Rd.  
Balto. Md. 21212**





1  
B-620

67 11178

BALTIMORE CITY HEALTH DEPARTMENT

67 11178

BIRTH NO.

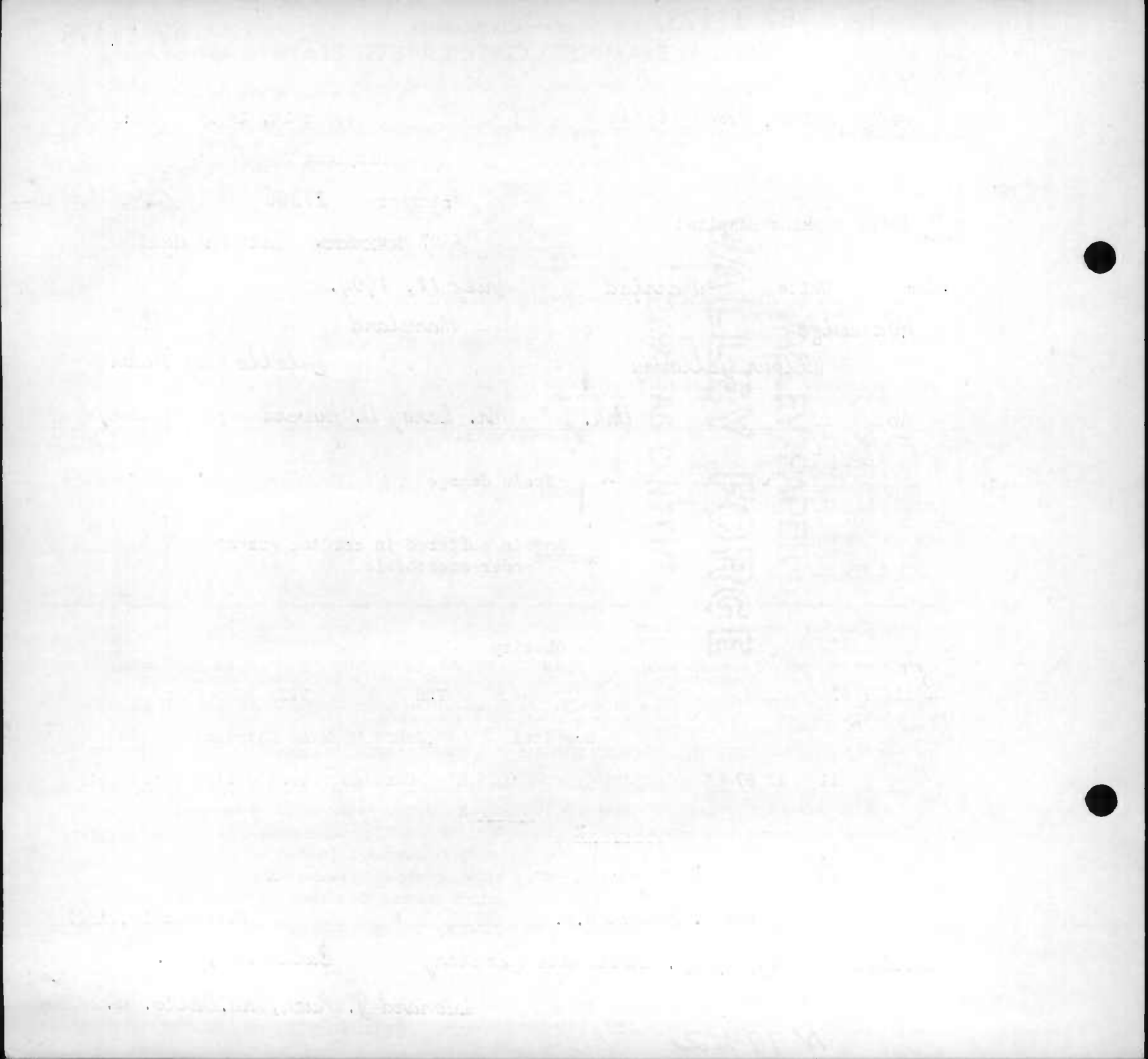
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>MARY BOWERS, May Estelle</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>November 20, 1967 1:50 a.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>33 Johns Hopkins Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>21206</b> D. STREET ADDRESS (If rural, give location) <b>4407 Marx Ave. Marx Avenue</b>			
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>July 11, 1904. 63</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wilbur Galloway</b>				14. MOTHER'S MAIDEN NAME <b>Estelle May Tudor</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Mr. Leroy D. Bowers</b>		ADDRESS <b>(Same)</b>	
18. CAUSE OF DEATH <b>E950X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Brain damage</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Anoxia suffered in cardiac arrest under anesthesia</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Obesity</b>				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>3 11/17/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Johns Hopkins Hospital</b>		21D. TIME OF INJURY (APPROX.) <b>11 17 67 ?</b>	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Cardiac arrest during anesthesia</b>					
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>November 20, 1967</b>							
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>11/24/67</b>		23C. NAME OF CEMETERY or CREMATORY <b>Baltimore Cemetery</b>		23D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>NOV 22 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		24C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md.</b>		ADDRESS <b>21214</b>	

N 999.2

✓



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11179

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE F. KETTELL

2. DATE AND HOUR PRONOUNCED DEAD

November 20, 1967 12:55 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4401 Cook Ave.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

June 21, 1904

9. AGE (In years  
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Building Contractor

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George F Kettell

14. MOTHER'S MAIDEN NAME

Betsy B Broughton

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs Thelma M Kettell

ADDRESS

Same

18.

581.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Cirrhosis  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/22/67

23C. NAME of CEMETERY or CREMATORY

Moreland Memorial

23D. LOCATION

Baltimore Maryland

November 20, 1967 (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 22 1967

24B. NAME OF REGISTRAR

Robert E. Farkas, M.D.

24C. FUNERAL DIRECTOR

Leonard J Ruck Inc. 5305 Harford Rd

U.S.A.

June 21, 1954

Dear Sir,

Referring to the letter of the 17th inst.

received

from the American

Embassy in London

concerning the matter of the

NO. 1

Circular

Yours faithfully

W. J. P. [Signature]

17/5/54

Encl.

Enclosed for the American Embassy in London

67 11180

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11180

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

IRVING STRANG

2. DATE AND HOUR PRONOUNCED DEAD

November 19, 1967 7:25 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1305 E. Lombard St.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

May 30, 1906.

9. AGE (In years  
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Unk.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

William F. Strang

14. MOTHER'S MAIDEN NAME

Barbara King

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Unk.

16. SOCIAL  
SECURITY NO.

Unk.

17. INFORMANT

ADDRESS

Miller Funeral Home, Sanford, N.C.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Chronic lung disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) ~~Pneumonia~~

Tuberculosis

(C)

Pneumonia

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 20, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/22/67.

23C. NAME of CEMETERY or CREMATORY

Jones Chapel Cemetery

23D. LOCATION

(City, town, or county)

Lee County, N.C.

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 22 1967

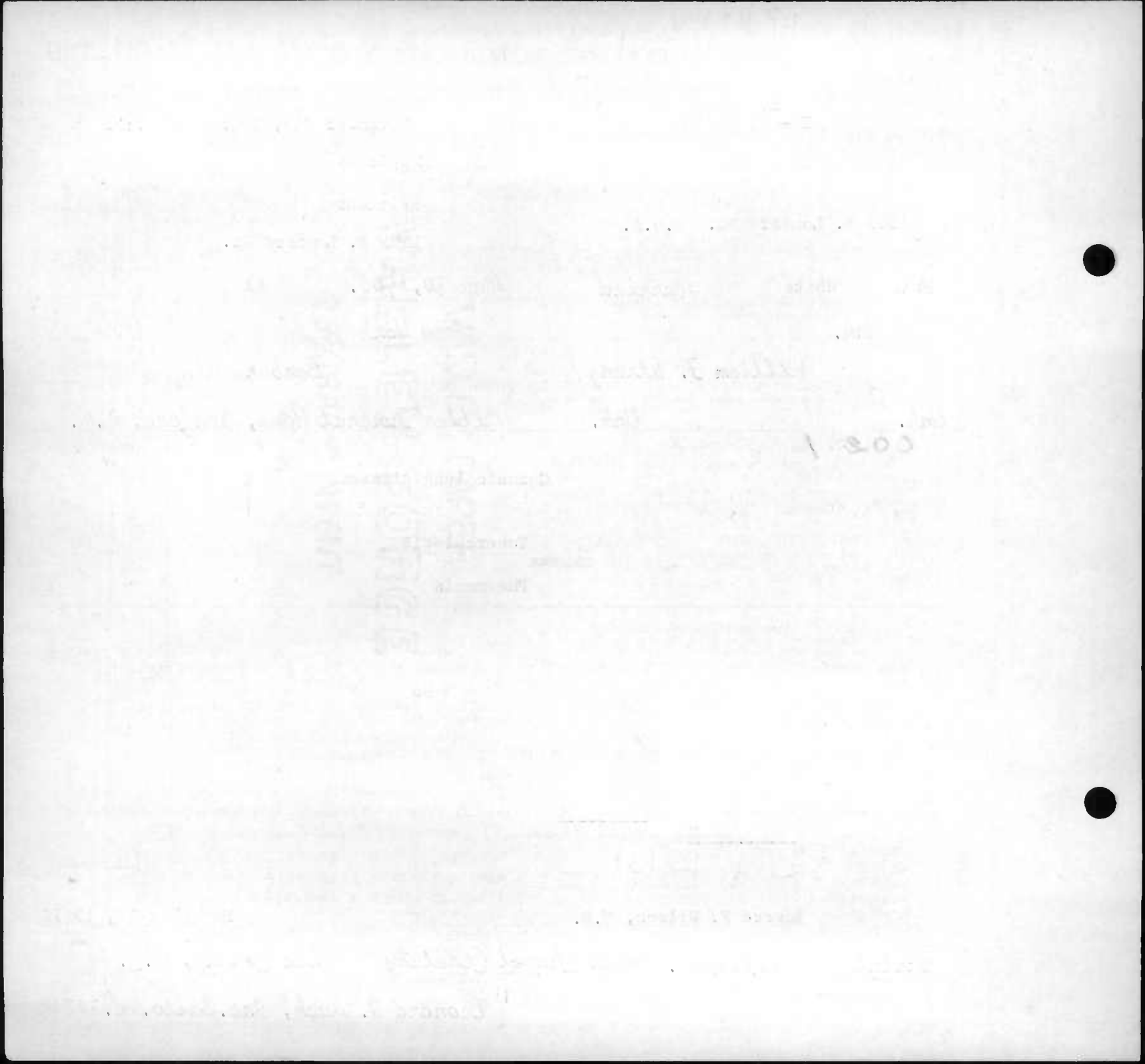
24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

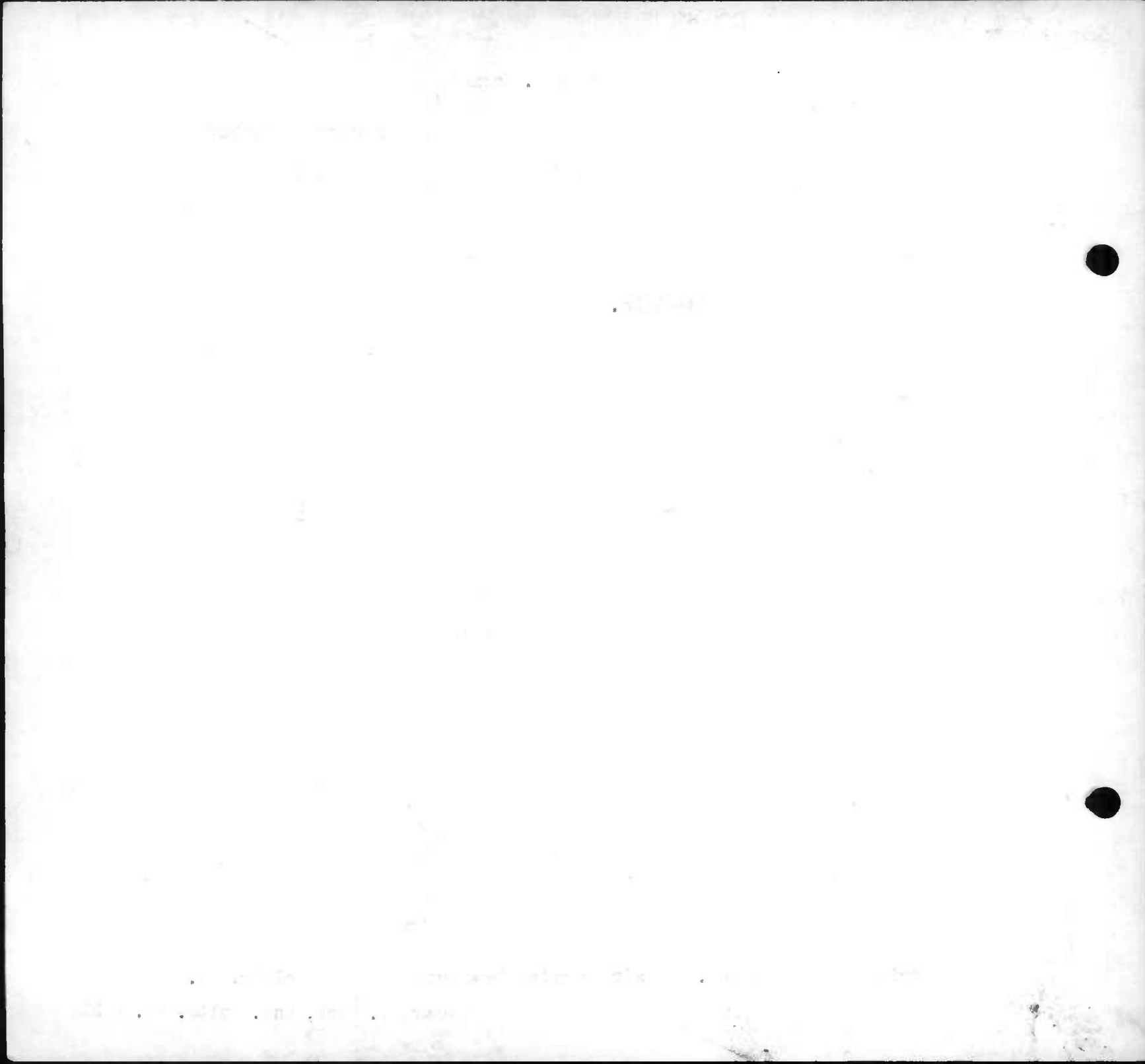
Leonard J. Ruck, Inc. Balto. Md. 21214



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67 11181					REGISTERED NO. 67 11181					
CERTIFICATE OF DEATH										
BIRTH NO.		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
					JAMES WARNT (James C. Warns)		11/20/67		1P. 4M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  Md. GENERAL HOSPITAL 48					A. STATE Md. <del>21085</del> Harford 6200					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) JOPPA 21085					
					D. STREET ADDRESS (If rural, give location) 3200 CLAYTON RD.					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 10/02/91	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY Steel Co.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME FRANCIS WARNT					14. MOTHER'S MAIDEN NAME ELIZABETH DAVIS					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-0135		17. INFORMANT EDITH WARNT			ADDRESS 3200 CLAYTON RD.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) DUE TO Uremia			INTERVAL BETWEEN ONSET AND DEATH 3 days.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulm. Embolism - Pulmonary edema - Anemia										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from 11/17/67 to 11/20/67 that (I) (we) last saw the deceased alive on 11/20/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Q. N. Maudsley					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 11/20/67		
23C. PHYSICIAN'S NAME (Type) Q. N. Maudsley					23D. ADDRESS 3200 CLAYTON RD.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/25/67		24C. NAME of CEMETERY or CREMATORY Belair Memorial Cemetery		24D. LOCATION (City, town, or county) (State) Belair, Md.				
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1967		25B. NAME OF REGISTRAR P. E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS				

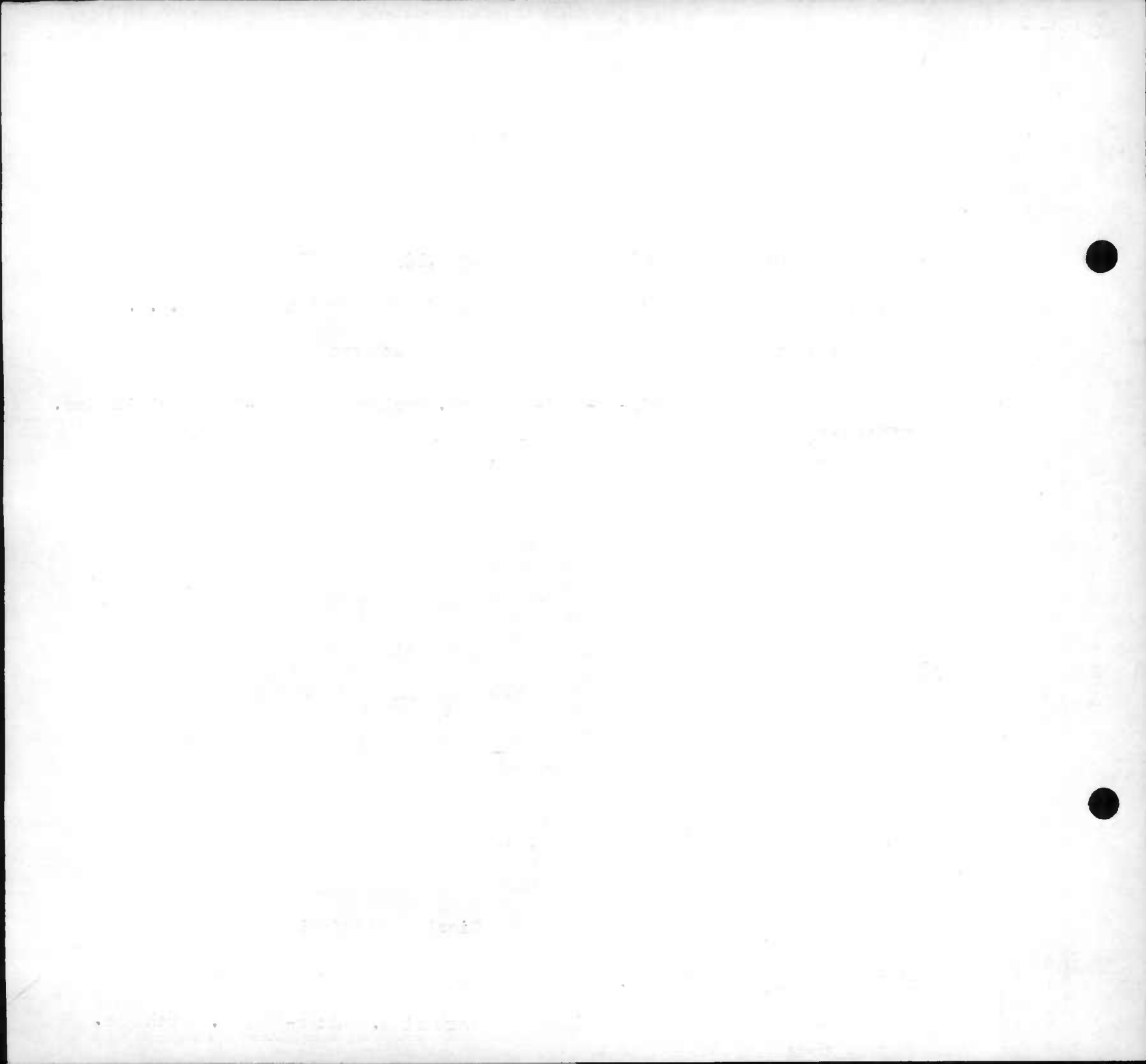




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">67 11182</span>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <span style="font-size: 1.5em;">67 11182</span></span> <span>CERTIFICATE OF DEATH</span> </div>					
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">GERTRUDE BAKER</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">11-16-67</span> <span style="float: right;">6:52 A.M.</span>		
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.5em;">42 SINAI Hospital</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span> <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <span style="font-size: 1.5em;">15-05</span> <b>D. STREET ADDRESS</b> (If rural, give location) <span style="font-size: 1.2em;">3223 Burleigh Ave #5</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">Female</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">Negro</span>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (specify) <span style="font-size: 1.2em;">Single</span>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">May 6, 1898</span>	<b>9. AGE</b> (In years lost birthday) <span style="font-size: 1.2em;">69</span>	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">None</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">None</span>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">None</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Baltimore Maryland</span>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>			<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Unknown</span>		
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Unknown</span>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">None</span>		
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">218-52-1066-T</span>			<b>17. INFORMANT ADDRESS</b> <span style="font-size: 1.2em;">Mrs. Gertrude Bolling-3223 Burleigh Ave.</span>		
<b>18. CAUSE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                  (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>                  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.             </div> <div style="width: 45%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>                  (A) <span style="font-size: 1.2em;">PULMONARY INFARCT</span>                  DUE TO                  (B) <span style="font-size: 1.2em;">PNEUMONIA</span>                  DUE TO                  (C)             </div> </div>					
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">11-14</span> 1967 to <span style="font-size: 1.2em;">11-16</span> 1967, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">11-16</span> 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">Edito C. GALLER</span> M.D.				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">11-16-67</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Edito C. GALLER</span> M.D.				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">Sinai Hospital</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">11/20/1967</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Mt. Auburn Cemetery</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore Maryland</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.5em;">NOV 22 1967</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Finkema</span>		<b>25C. FUNERAL DIRECTOR ADDRESS</b> <span style="font-size: 1.2em;">Herbert E. Nutter-3035 W. North Ave.</span>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11183</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>67 11183</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Sally Ambler Kempton		November 17, 1967 11:05 a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland			
00 4220 Wickford Road		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 4220 Wickford Road			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 2/23/1887	9. AGE (In years last birthday) 80	10. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales		10B. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) Richmond, Va.	
13. FATHER'S NAME James M. Ambler			14. MOTHER'S MAIDEN NAME Eliza Randolph		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT William Kempton, 806 Mercantile Trust Bldg.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 331 XI		CAUSE OF DEATH (A) DUE TO Pneumonia & delirium		INTERVAL BETWEEN ONSET AND DEATH 27 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO CVA, right		4 days	
		(C) DUE TO gun fire from A.S.		years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. previous CVA, left					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/13/67 19 to Nov 17 1967, that (I) (we) last saw the deceased alive on Nov 16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Philip Whittlesey				23B. DATE SIGNED 11/20/67	
23C. PHYSICIAN'S NAME (Type) Philip Whittlesey				23D. ADDRESS 600 W. Belvedere Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/20/67		24C. NAME OF CEMETERY or CREMATORY Greenmount	
24D. LOCATION Baltimore		24E. LOCATION (City, town, or county) (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.	

1900  
1901  
1902

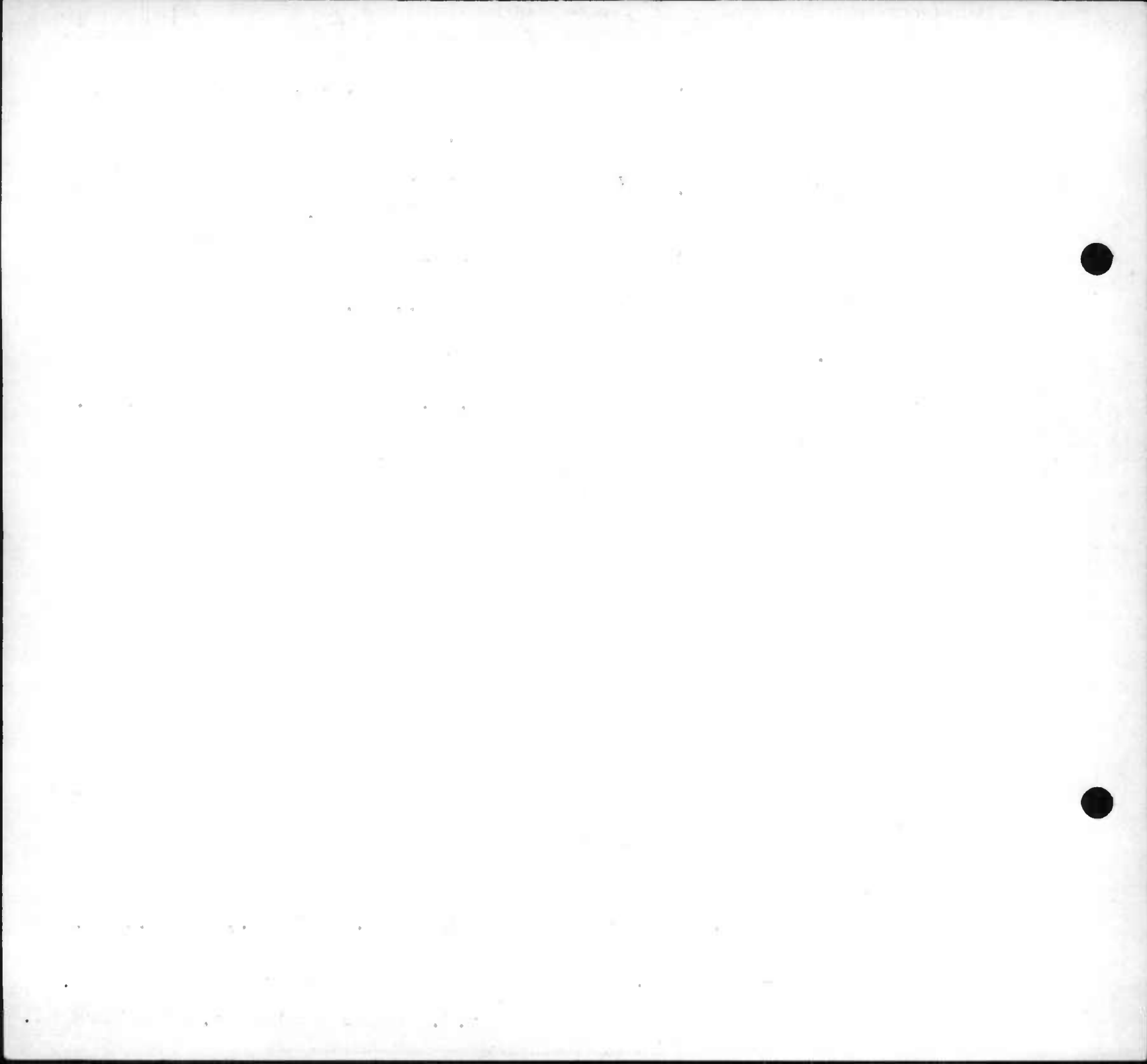
1903

1904

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 11184	
67 11184				CERTIFICATE OF DEATH	
BIRTH NO. M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Charlotte R. McIntosh		Nov. 19, 1967 9 AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE Md.		
00 4300 Rugby Rd.			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.		
			D. STREET ADDRESS (If rural, give location) 4300 Rugby Rd.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4-16-1880	9. AGE (In years last birthday) 87	If Under 1 Yr. Months: Oays: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph H. Rieman			14. MOTHER'S MAIDEN NAME Annie Lowe		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS J. R. McIntosh Monkton, Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 606 X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Interval Between Onset and Death Recto-Vesical-Vag Fissure 4 yrs		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Interval Between Onset and Death Ant. Jeleroe		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Nov 16-67 1967 to Nov 19 1967, that (I) (we) last saw the deceased alive on Nov 16-67 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Walter A. Baetjer			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Nov 20-67
23C. PHYSICIAN'S NAME (Type) Walter A. Baetjer			23D. ADDRESS 1010 St. Paul St., Balto., Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11-21-67	24C. NAME OF CEMETERY or CREMATORY St. Thomas'		24D. LOCATION (City, town, or county) (State) Garrison Forest Md.	
25A. DATE RECEIVED BY HEALTH DEPT. NOV 22 1967		25B. NAME OF REGISTRAR Philip E. Taylor		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11185

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

67 11185

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

FREDERICK REPP

2. DATE AND HOUR OF DEATH

NOV. 17, 1967 8:20 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

THE UNION MEMORIAL HOSPITAL

44

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

2937 FAIT

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

09-26-08

9. AGE (In years  
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

PLUMBER

10B. KIND OF BUSINESS OR INDUSTRY

PLUMBER

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF  
WHAT COUNTRY?

AMERICAN

13. FATHER'S NAME

ADOLPH REPP (D)

14. MOTHER'S MAIDEN NAME

LENA MIER

(D)

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL  
SECURITY NO.

—

17. INFORMANT

Mrs. Anna Repp

ADDRESS

2937 Fait Ave, Baltimore, Md.

18. 204.4 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) CHRONIC LEUKEMIA  
DUE TOINTERVAL BETWEEN  
ONSET AND DEATH

4 years

(B)  
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

D

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (Notably medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Not While  
Work At Work

21F. HOW DID INJURY OCCUR?

22. I certify that ~~he~~ (this hospital) attended the deceased from 11-13 1967 to 11-17 1967,  
that ~~he~~ (we) last saw the deceased alive on 11-16 1967 and that in ~~my~~ (our) opinion death occurred on the date  
and hour and from the causes stated above. ~~He~~ (We) (did) ~~not~~ view the body after death.

23A. SIGNATURE

Cesar F. Climaco

M.D.

Attending  
Phys.Med.  
DirectorStaff  
Phys.

23B. DATE SIGNED

11-17-67

23C. PHYSICIAN'S  
NAME (Type)

CESAR F. CLIMACO

M.D.

23D. ADDRESS

THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

11/20/67

24C. NAME OF CEMETERY or CREMATORY

St. Stanislaus Cemetery Baltimore, Md.

24D. LOCATION

(City, town, or county)

(State)

25A. DATE RECD BY HEALTH DEPT.

NOV 22 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Nicholas T. Matthews

ADDRESS

3021 Eastern Ave, Baltimore, Md.

THE UNION RESOLUTION

QUALITY  
EXCELLENCE  
PART

02-25-03

MADE WITH

EXCELLENCE

MADE WITH

EXCELLENCE

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EXCELLENCE

EXCELLENCE

EXCELLENCE

EXCELLENCE

EXCELLENCE

EXCELLENCE



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 11186	
67 11186				BIRTH NO.	
M.E. CASE NO.				BIRTH NO.	
1. NAME OF DECEASED (Type or Print) <u>GALANOS, William J.</u>			2. DATE AND HOUR OF DEATH <u>11-16-67</u> <u>8 45</u> AM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u> <u>34</u>			A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>623 S. Oldham Street</u>		
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>5-15-95</u>	9. AGE (In years lost birthday) <u>72</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not Known</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Greece</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>John Galanos</u>		
14. MOTHER'S MAIDEN NAME <u>?</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW II</u>		
16. SOCIAL SECURITY NO. <u>213-07-0591</u>			17. INFORMANT <u>Patients Chart</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>163X I</u> <u>CARCINOMA OF LUNG</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 MONTHS</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 4</u> <u>1967</u> to <u>Nov 16</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 16</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>Nov 16 '67</u>	
23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>484-782</u>		24B. DATE <u>11/21/67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat'l Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE RECEIVED BY HEALTH DEPT. <u>NOV 22 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farkema</u>		25C. FUNERAL DIRECTOR <u>Nicholas T. Matthews</u> <u>3021 Eastern Ave, Baltimore, Md.</u>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 11187		CERTIFICATE OF DEATH		Registered No. 67 11187	
1. NAME OF DECEASED (Type or Print) <b>LOUVERIA MAY SAYRE</b>				2. DATE AND HOUR OF DEATH <b>11-19-1967</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3708 PENNINGTON AVE. BALTO. 21226, MD.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>WEST VIRGINIA</b> B. COUNTY <b>GRAFTON</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>GRAFTON</b> D. STREET ADDRESS (If rural, give location) <b>V-45</b>					
5. SEX <b>F</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>Oct 16, 1881</b>		9. AGE (In years last birthday) <b>86</b>		10. If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>AMON MARTIN</b>				14. MOTHER'S MAIDEN NAME <b>Rachel Snyder</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>MR. R. W. SAYRE</b>				
					ADDRESS <b>3708 Pennington Ave</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>422.1 I</b>				CAUSE OF DEATH (A) <b>Arteriosclerotic C.V. disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) (C) 					
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<b>Bronchopneumonia</b>				<b>1 week</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>June 19 64</b> to <b>Nov 9 19 67</b> , that (I) (we) last saw the deceased alive on <b>11/11 19 67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b> Sidney R. Gehlert</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11/19/67</b>			
23C. PHYSICIAN'S NAME (Type) <b>SIDNEY R. GEHLERT</b>				23D. ADDRESS <b>4700 Pennington Ave.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-22-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Bluenort Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Grafton, W. Va.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 22 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>John H. Hahn Funeral Home</b>		ADDRESS <b>4200 Pennington Ave Balto 21226, Md</b>			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 11188</u>	
BIRTH NO. <u>67 11188</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>WALTER L. BRAGER</u>		2. DATE AND HOUR OF DEATH <u>11/18/67</u> <u>3:15 P.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>ST. AGNES HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE 21226</u> D. STREET ADDRESS (If rural, give location) <u>4940 PENNINGTON AVENUE</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>06/28/87</u>	9. AGE (in years last birthday) <u>80</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>General Ref. Cng</u>		11. BIRTHPLACE (State or foreign country) <u>WARSAW, POLAND</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217 01 3851</u>		17. INFORMANT ADDRESS <u>ST. AGNES HOSPITAL-CATON &amp; WILKENS AVE</u>	
18. <u>420.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Anterior wall M.I. Heart Dis.</u>		CAUSE OF DEATH (A) DUE TO <u>Bronch chronic Asthma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Acute pulm. edema</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>XX</u> (this hospital) attended the deceased from <u>10/29/67</u> 19 to <u>11/18/67</u> 19, that <u>XX</u> (we) lost saw the deceased alive on <u>11/18/67</u> 19 and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (We) (did not) view the body after death.					
23A. SIGNATURE <u>B. Angor George</u>		23B. DATE SIGNED <u>11/18/67</u>		23C. PHYSICIAN'S NAME (Type) <u>ANGOR, GEORGE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-22-67</u>		24C. NAME of CEMETERY or CREMATORY <u>Meadowdale Mem. Cam.</u>	
24D. LOCATION (City, town, or county) (State) <u>Elkridge, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 22 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>	
25C. FUNERAL DIRECTOR <u>John H. Hahn Funeral Home</u>		25D. ADDRESS <u>4200 Pennington Ave. Balto 21226</u>			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		67 11189		CERTIFICATE OF DEATH		Registered No. 67 11189	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>MAUD SUTTON WILDRICK</b>				2. DATE AND HOUR OF DEATH <b>11/19/67 2:00 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>FRANKLIN SQUARE HOSP</b>				A. STATE <b>MD</b> B. COUNTY <b>BALTO. CO.</b>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>TOWSON 4 53-00</b>			
D. STREET ADDRESS (If rural, give location) <b>6615-A ELLSMERE PI. 39</b>							
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>2/23/90</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>NEW JERSEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>MOSES FISH</b>				14. MOTHER'S MAIDEN NAME <b>SUSAN HING LINE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO NOT KNOWN</b>				16. SOCIAL SECURITY NO. <b>145-38-2038</b>		17. INFORMANT ADDRESS <b>HOSP. CHART</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRAL THROMBOSIS</b>				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>1-2 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTEROSCLEROSIS</b>				(B) DUE TO		?	
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO !!</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11/17/67</b> to <b>11/19/67</b> , that (I) (we) lost saw the deceased alive on <b>11/19/67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Heather E. Evans</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/19/67</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <b>Franklin Square Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11-23-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>UNION BRICK</b>		24D. LOCATION (City, town, or County) (State) <b>BLAIRTOWN N.D.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 22 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>L. F. EVANS, JR. SON 8802 NANTOWN RD.</b>			

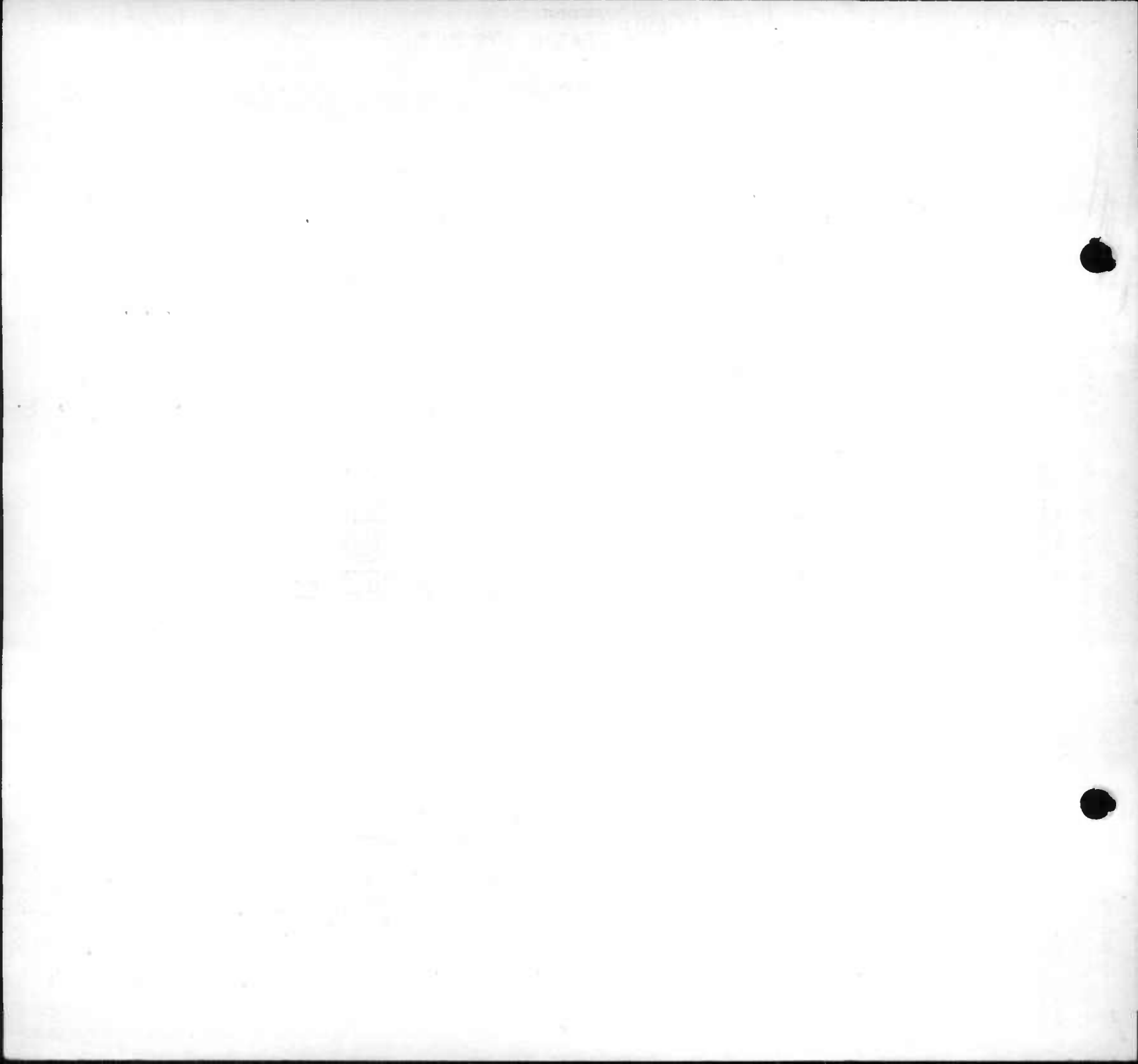




## FUNERAL DIRECTOR: IMPORTANT

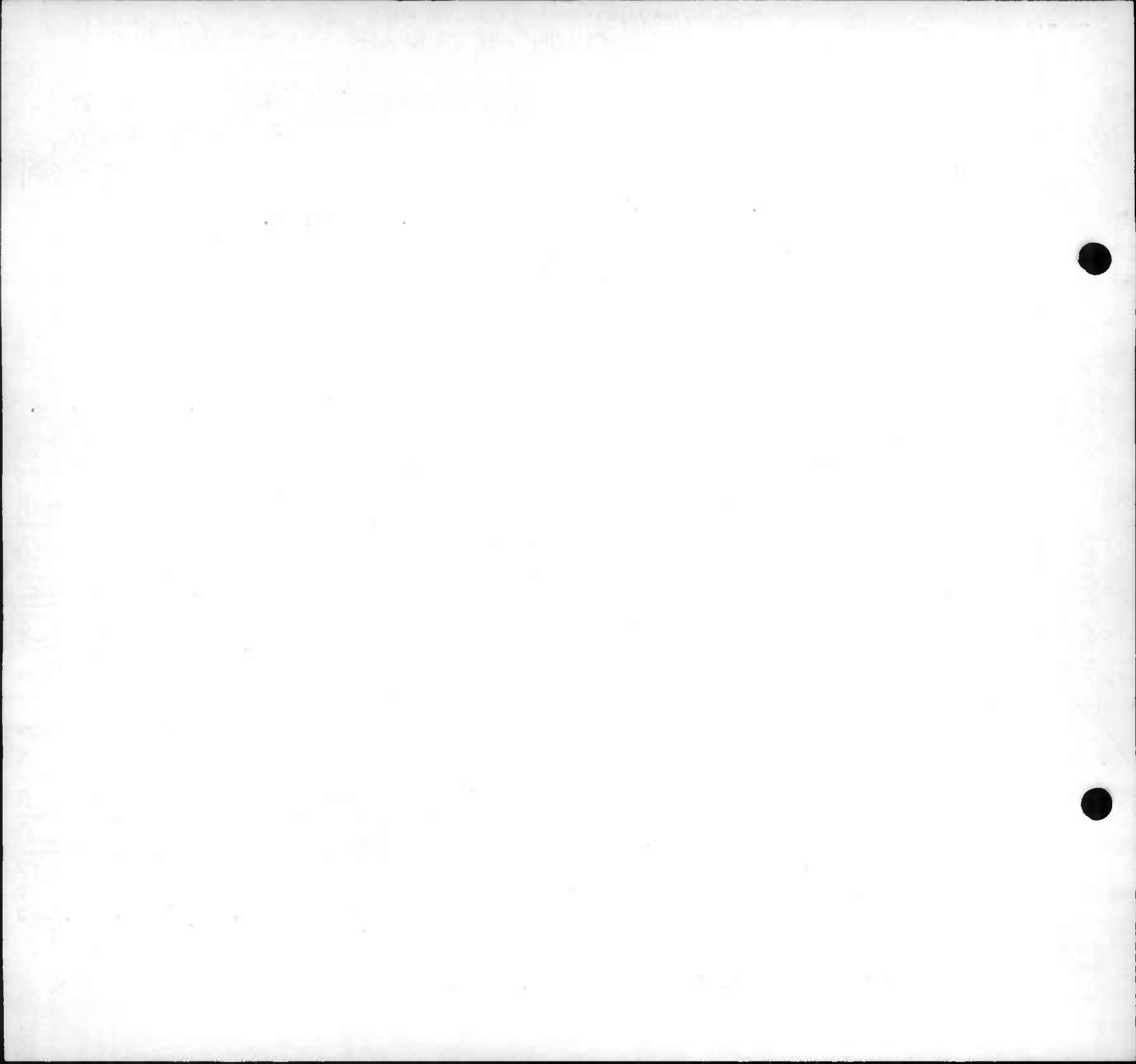
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 11190	
BIRTH NO. <b>K-520 67 11190</b>		M.E. CASE NO. <b>67-22913</b>		1. NAME OF DECEASED (Type or Print) <b>Kevin Gil</b>	
2. DATE AND HOUR OF DEATH <b>11/16/67 10:35 A.M.</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>Baltimore City Hospitals</b>			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		D. STREET ADDRESS (If rural, give location) <b>1625 Darley Ave.</b>			
6. SEX <b>Female</b>	7. RACE <b>Negro</b>	8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Never married</b>	9. DATE OF BIRTH <b>11/16/67</b>	10. AGE (In years, lost birthday) <b>2</b>	11. If Under 1 Yr. Months: Days: Hours: Min. <b>2</b>
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		13. KIND OF BUSINESS OR INDUSTRY		14. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
15. FATHER'S NAME <b>Not Given</b>		16. MOTHER'S MAIDEN NAME <b>Brenda King</b>		17. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		19. SOCIAL SECURITY NO.		20. INFORMANT <b>BCH: Records 4940 Eastern Ave. Baltimore, Md.</b>	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		22. CAUSE OF DEATH (A) <b>Immaturity</b> (B) <b>Placenta previa</b> (C)		23. INTERVAL BETWEEN ONSET AND DEATH	
24. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
26. MEDICAL CERTIFICATION		27. MEDICAL CERTIFICATION			
28. DATE OF OPERATION <b>2</b>		29. CONDITION FOR WHICH OPERATION WAS PERFORMED		30. AUTOPSY? (Yes or No) <b>YES</b>	
31. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		32. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		33. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
34. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		35. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		36. HOW DID INJURY OCCUR?	
37. I certify that (I) (this hospital) attended the deceased from <b>11/16 8:30 am 19 67</b> to <b>11/16 10:35 am 19 67</b> that (I) (we) last saw the deceased alive on <b>10 35 am 19 67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
38. SIGNATURE <b>David Juan</b>		39. M.D. <b>David Juan</b>		40. DATE SIGNED <b>11/16/67</b>	
41. PHYSICIAN'S NAME (Type) <b>David Juan</b>		42. ADDRESS <b>4940 Eastern Ave. Baltimore, Maryland</b>			
43. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		44. DATE <b>11-17-67</b>		45. NAME OF CEMETERY OR CREMATORY <b>Baltimore City Hospitals</b>	
46. LOCATION (City, town, or county) <b>Baltimore</b>		47. STATE <b>Maryland</b>			
48. DATE REC'D BY HEALTH DEPT. <b>NOV 22 1967</b>		49. NAME OF REGISTRAR <b>Robert E. Jarboe, Md</b>		50. FUNERAL DIRECTOR <b>HOSPITAL DISPOSAL</b>	
51. ADDRESS		52. ADDRESS			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 11191 4	
BIRTH NO. 5-162 67 11191		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Spears Boy Joann</i>		2. DATE AND HOUR OF DEATH <i>11/15/67 5<sup>25</sup>pm.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <i>Md</i> B. COUNTY <i>city</i>			
31 <i>Baltimore City Hospitals</i> 4940 Eastern Ave. Baltimore, Maryland #21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		<i>Baltimore</i> 18-01	
		D. STREET ADDRESS (If rural, give location)		<i>810 W. Saratoga St.</i>	
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>never married</i>	8. DATE OF BIRTH <i>11/15/67</i>	9. AGE (In years last birthday) <i>1 day</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <i>Joann</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS #21224 <i>BCH: Records 4940 Eastern Ave. Baltimore, Md.</i>		
18. <i>773.51</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Immaturity - Respiratory</i> DUE TO (B) <i>Distress Syndrome</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>9 hrs 25 minutes</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Immaturity</i>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <i>Yes</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>11/15/67</i> 19 <i>67</i> to <i>11/15</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>11/15/67</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>David Juan</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <i>11/15/67</i>		
23C. PHYSICIAN'S NAME (Type) <i>David Juan</i>		23D. ADDRESS <i>4940 Eastern Ave. Baltimore, Maryland Baltimore City Hospital #21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)		
<i>Cremation</i>	<i>11-17-67</i>	<i>Baltimore City Hospitals Baltimore, Maryland</i>	<i>21224</i>		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR <i>Robert E. Farber</i>	25C. FUNERAL DIRECTOR		ADDRESS	
<i>NOV 22 1967</i>		<i>HOSPITAL DISPOSAL</i>			



6-650

67 11192

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11192

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <b>JESSE GRAHAM</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>October 22, 1967 1:15 A.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3/99 Church Home and Hospital (DOA)</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Montgomery</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Stewartstown</b> D. STREET ADDRESS (If rural, give location) <b>Route 1</b>	
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>35</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>E982X I</b> <b>Exsanguination due to stab wound of chest involving pulmonary artery and right lung.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Cafe</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>917 E. Fayette Street</b>		21D. TIME OF INJURY (APPROX.) <b>10/22/67 1:00 A.</b>	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Stabbed during an argument</b>	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> DATE SIGNED <b>10/22/67</b>			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE <b>11/29/67</b>	
23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
24A. DATE REC'D BY HEALTH DEPT. <b>NOV 22 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Farley</b>	
24C. FUNERAL DIRECTOR		ADDRESS	

N 87312

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCHD

WALLEY BOWLING

WALLEY BOWLING

WALLEY BOWLING

67 11193

BALTIMORE CITY HEALTH DEPARTMENT

67 11193

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM GERMAN

2. DATE AND HOUR PRONOUNCED DEAD

October 9, 1967

?

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

PHILADELPHIA Pa.

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street  
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Philadelphia

D. STREET ADDRESS (If rural, give location)

1724 N. 17th Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

50?

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

E925.13 + 322.2

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Asphyxia

due to the position of the body

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Alcohol intoxication

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Factory

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Domestic Rag Co. 455 N. Guilford Ave.

21D. TIME OF INJURY  
(APPROX.)

Bet. Month (Day) (Year) Bet. Hour (Min.)

10. 6-9 67 4:30- P

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Was found on top of bale, covered with a

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

11/20/67

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

NOV 22 1967

R. E. Farley, M.D.

MORTUARY SERVICE - BCHD

RD

11/2/40

11/2/40



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 11194	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. 67 11194</span> <span>CERTIFICATE OF DEATH</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>M.E. CASE NO. 17-23390</span> <span>1. NAME OF DECEASED (Type or Print) <b>TOPPER, BABY BOY</b></span> <span>2. DATE AND HOUR OF DEATH <b>11-8-67 12<sup>10</sup> A.M.</b></span> </div>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Church Home &amp; Hospital - 1500 N. Broadway - Baltimore, Maryland 21231</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Baltimore</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give Township) <b>Baltimore, Maryland 53-00</b> D. STREET ADDRESS (If rural, give location)		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>11-7-67</b>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <b>2 03</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Louise Topper</b>			14. MOTHER'S MAIDEN NAME <b>Jo Ann Topper</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war and dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hydrocephalus congenital</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>11-7-1967</b> to <b>11-8-1967</b> , that (I) (we) last saw the deceased alive on <b>11-8-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. Veneracion</b> M.D.			23B. DATE SIGNED <b>11/9/67</b> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		
23C. PHYSICIAN'S NAME (Type) <b>VERERACION</b>			23D. ADDRESS <b>Church Home &amp; Hospital - 1500 N. Broadway - Baltimore, Maryland</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <b>11/17/67</b>	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION <b>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 22 1967</b>	25B. NAME OF REGISTRAR <b>Ruben E. Fajana</b>	25C. FUNERAL DIRECTOR ADDRESS			

11-7-67

615

John Papp

John Papp

Hydrocephalus

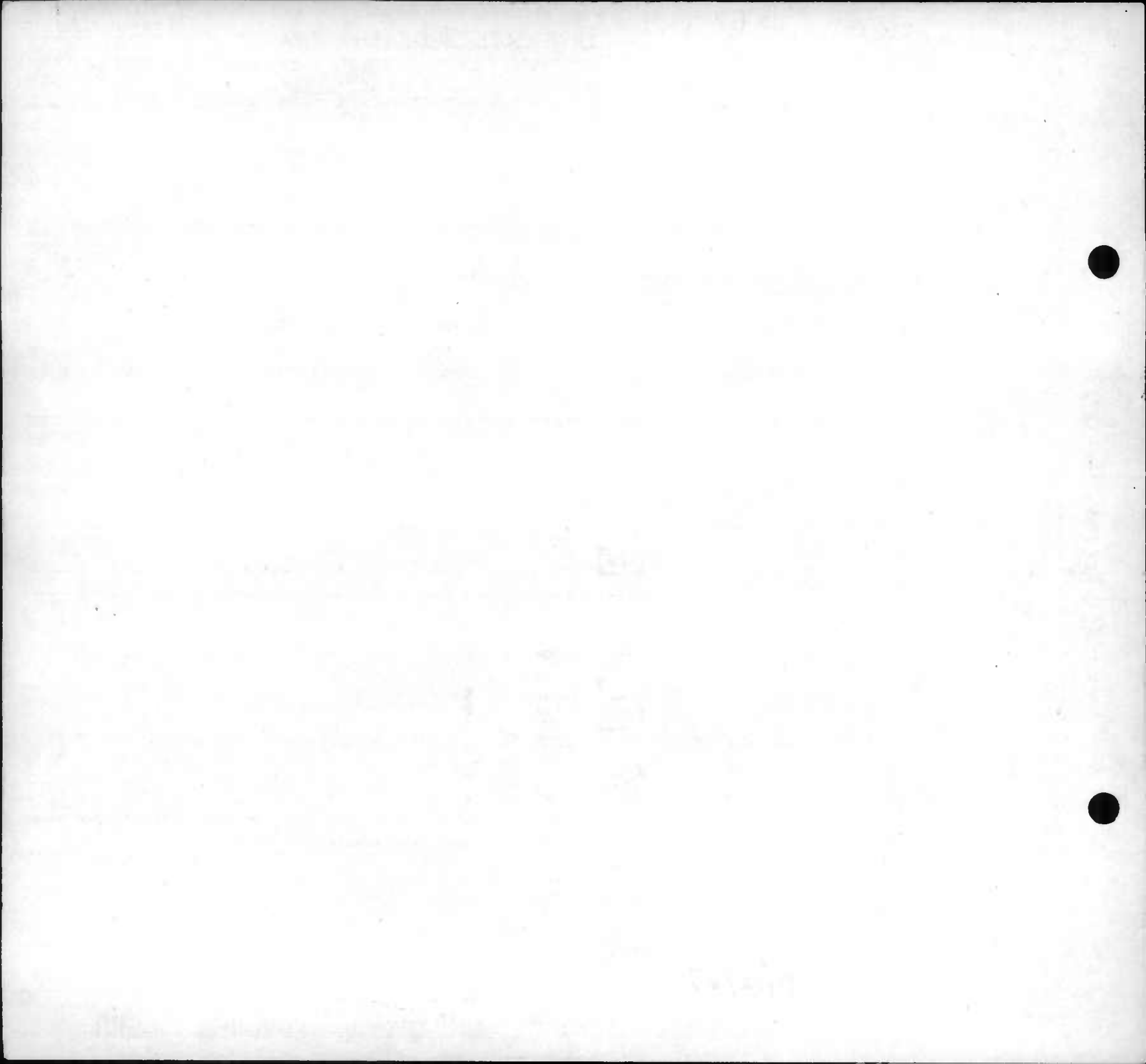
11-8-67 11-5-67

11-7-67

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <u>67 11195 4</u>
BIRTH NO. <u>67-22352</u> <u>67 11195</u>										
M.E. CASE NO.										
1. NAME OF DECEASED (Type or Print) <u>SCOTT BABY BOY</u>					2. DATE AND HOUR OF DEATH <u>11/10/67 12:25pm</u>					M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 LUTHERAN HOSPITAL INC.</u> (If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>					<u>16-07</u>
					D. STREET ADDRESS (If rural, give location) <u>2707 Ellicott Drive</u>					
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <u>11/10/67</u>		9. AGE (In years last birthday)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Vernon T Jr.</u>					14. MOTHER'S MAIDEN NAME <u>Sheila Ball</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
18. <u>776 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Immaturity</u> CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs 28 min</u>										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>11/10</u> 19 <u>67</u> to <u>11/10</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/10</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Synob</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>11/10/67</u>		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D. <u>ANATOMY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>11/16/67</u>		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)				
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 22 1967</u>			25B. NAME OF REGISTRAR <u>Robert E. Faulkner</u>			25C. FUNERAL DIRECTOR ADDRESS <u>MORTUARY SERVICE - BCHD</u>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>67-22177</u>		67 11196		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67 11196</u>	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Babn aiel Roushiep</u>				2. DATE AND HOUR OF DEATH <u>9:48 am 11-3-67</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>16-05</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>H2 Sinai Hospital Baltimore</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>2419 Harlem Ave -</u>			
5. SEX <u>F</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>81-3-67</u>	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Edward Roushiep</u>				14. MOTHER'S MAIDEN NAME <u>Debas -</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>5</u>		17. INFORMANT ADDRESS	
18. <u>726X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Immediate</u>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO			
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>11-3</u> 19 <u>67</u> to <u>11-3</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>James L. Bann</u> M.D.				23B. DATE SIGNED <u>11-3-67</u>		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS <u>ANATOMIC BOARD OF MARYLAND</u> M.D.				23E. FUNERAL DIRECTOR ADDRESS <u>UNIVERSITY MEDICAL SCHOOL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>11/14/67</u>		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 22 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairley</u>		25C. FUNERAL DIRECTOR ADDRESS <u>MORTUARY SERVICE - BCHD</u>			

18-1-18 18-1-18 18-1-18

18-1-18 18-1-18 18-1-18

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18-1-18 18-1-18 18-1-18

18-1-18 18-1-18 18-1-18

18-1-18

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11197 4	
BIRTH NO. 67-17589 67 11197		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Baby Boy Greene</u>		September 4, 1967 10:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>LUTHERAN HOSPITAL OF MARYLAND, INC.</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
		D. STREET ADDRESS (If rural, give location) <u>2557 Harlem Avenue</u>	
5. SEX <u>Male</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>9-4-67</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	9. AGE (In years last birthday) <u>1</u>
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas Marshall Greene</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Eldridge</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT ADDRESS	
18. <u>776 XI</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Immaturity</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO	
INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-4-67</u> 19 to <u>9-4-67</u> 19, that (I) (we) last saw the deceased alive on <u>9-4-67</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>M. R. FARZANFAR</u>		23B. DATE SIGNED <u>11-15-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>M. R. FARZANFAR</u>		23D. ADDRESS <u>2557 Harlem Avenue</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>11/14/67</u>		24B. DATE	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 22 1967</u>		25B. NAME OF REGISTRAR <u>John E. Farber</u>	
25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>		25D. ADDRESS	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11198

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

67 11198

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

REAHLE ANNA ERNESTINE

2. DATE AND HOUR OF DEATH

11-19-67 4:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1934 W. BALTIMORE ST.

5. SEX

F

6. RACE

WHITE

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
NEVER MARRIED

8. DATE OF BIRTH

10-20-11

9. AGE (In years last birthday)

56

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN REAHLE

14. MOTHER'S MAIDEN NAME

THERESA WETZLER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

316-46-3301

17. INFORMANT

John J. REAHLE, Jr. 11-DUTTON AVE

ADDRESS

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Brain tumor & Panhypopituitarism  
Adrenal atrophy

(B) DUE TO

Acute Bronchopneumonia

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Mc Jannet Rd.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-8 1967 to 11-19 1967, that (I) (we) last saw the deceased alive on 11-19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Paul V. Desquitado

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

PAUL V. DESQUITADO

M.D.

23D. ADDRESS THE UNION MEMORIAL HOSPITAL

UNION MEMORIAL HOSP.

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

11/22/67

24C. NAME OF CEMETERY or CREMATORY

Greenwood Cemetery

24D. LOCATION

(City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 22 1967

25B. NAME OF REGISTRAR

Robert E. Fairbank

25C. FUNERAL DIRECTOR

W. J. Whippert

ADDRESS

300 E. TAYLOR ST.

THE OFFICE OF THE ATTORNEY GENERAL

DEPARTMENT OF JUSTICE

1  
A-415

67 11199 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11199

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES

H.

ALBAN

2. DATE AND HOUR PRONOUNCED DEAD

November 18, 1967

9:17 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

33

Johns Hopkins Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Middle River (20)

53-00

D. STREET ADDRESS (If rural, give location)

107 Selfridge Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

March 7, 1942

9. AGE (In years  
last birthday)

25

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Bricklayer

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Baltimore Co., Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Alban

14. MOTHER'S MAIDEN NAME

Grace Main

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

--

16. SOCIAL  
SECURITY NO.

214 38 1882

17. INFORMANT

Blanche Alban

ADDRESS

Same

18.

E 816.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Multiple Injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Route 40 and Allender Road

53-00

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)  
11/18/67 8:37 P.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Passenger in auto-  
tractor trailer collision

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

11/19/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/22/67

23C. NAME OF CEMETERY or CREMATORY

Gardens of Faith Cemetery

23D. LOCATION

(City, town, or county)

Baltimore Co., Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 22 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

James E. Bruzdinski 1407 Eastern Ave.

ADDRESS

1-1-1

107 Bell Street  
New York 100

March 1, 1942  
Mr. J. Edgar Hoover

Director  
Federal Bureau of Investigation

Dear Sir:  
Enclosed for you are two copies of a letterhead memorandum

dated and captioned as above.

Very truly yours,  
J. Edgar Hoover  
Director

Very truly yours,  
J. Edgar Hoover  
Director

Very truly yours,  
J. Edgar Hoover  
Director

Very truly yours,  
J. Edgar Hoover  
Director

Very truly yours,  
J. Edgar Hoover  
Director

Very truly yours,  
J. Edgar Hoover  
Director

Very truly yours,  
J. Edgar Hoover  
Director

Very truly yours,  
J. Edgar Hoover  
Director

1  
G-620

67 11200

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11200

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JAMES

GRUZS

2. DATE AND HOUR PRONOUNCED DEAD

November 18, 1967

9:17 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Johns Hopkins Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Middle River (20)

D. STREET ADDRESS (If rural, give location)

50 Victoria Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Feb 24, 1931

9. AGE (In years  
last birthday)

36

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Sheet Metal Worker

10B. KIND OF BUSINESS OR INDUSTRY

Sheet Metal Shop

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

James W. Gruzs, Sr.

14. MOTHER'S MAIDEN NAME

Anna Cernowski

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

217 26 6959

17. INFORMANT

Constance I. Gruzs

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Multiple Traumatic Injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Route 40 and Allender Road

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
11/18/67 8:37 P. m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Driver in auto-  
tractor trailer collision.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/19/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/22/67

23C. NAME OF CEMETERY or CREMATORY

Holly Hill Memorial Gardens Baltimore, Maryland

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 22 1967

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

Bruzdzinski Funeral Home 1407 Eastern Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 11201</u>	
BIRTH NO. <u>67 11201</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Jennie H. Taite</u>		2. DATE AND HOUR OF DEATH <u>Nov 19 1967</u> <u>9:00 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>40 Ardleigh Nursing Home</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>27-13</u> D. STREET ADDRESS (If rural, give location) <u>5007 Roland Ave</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never Married</u>	8. DATE OF BIRTH <u>July 20 1880</u>	9. AGE (In years last birthday) <u>87</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Dress Manufacturer</u>		11. BIRTH PLACE (State or foreign country) <u>Nebraska</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Robert A Taite</u>		14. MOTHER'S MAIDEN NAME <u>Jane C Clarke</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>213 28 4301</u>		17. INFORMANT <u>Robert T Mac Lennan</u> ADDRESS <u>5007 Roland Ave</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>450.01</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Arteriosclerosis</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1962</u> to <u>Nov 19 1967</u> . that (I) <del>was</del> last saw the deceased alive on <u>Nov 19</u> 19 <u>67</u> and that in (my) <del>your</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) (did not) view the body after death.					
23A. SIGNATURE <u>William J Helfrich</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>11-21-67</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>		24B. DATE <u>11-22-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park Cem</u>	
24D. LOCATION (City, town, or county) (State) <u>Woodlawn Bk H Co Mo</u>		25A. DATE RECEIVED BY HEALTH DEPT. <u>NOV 25 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Burpee Funeral Home 3631 Falls Rd</u> <u>By Norman W. Burpee Jr</u>			

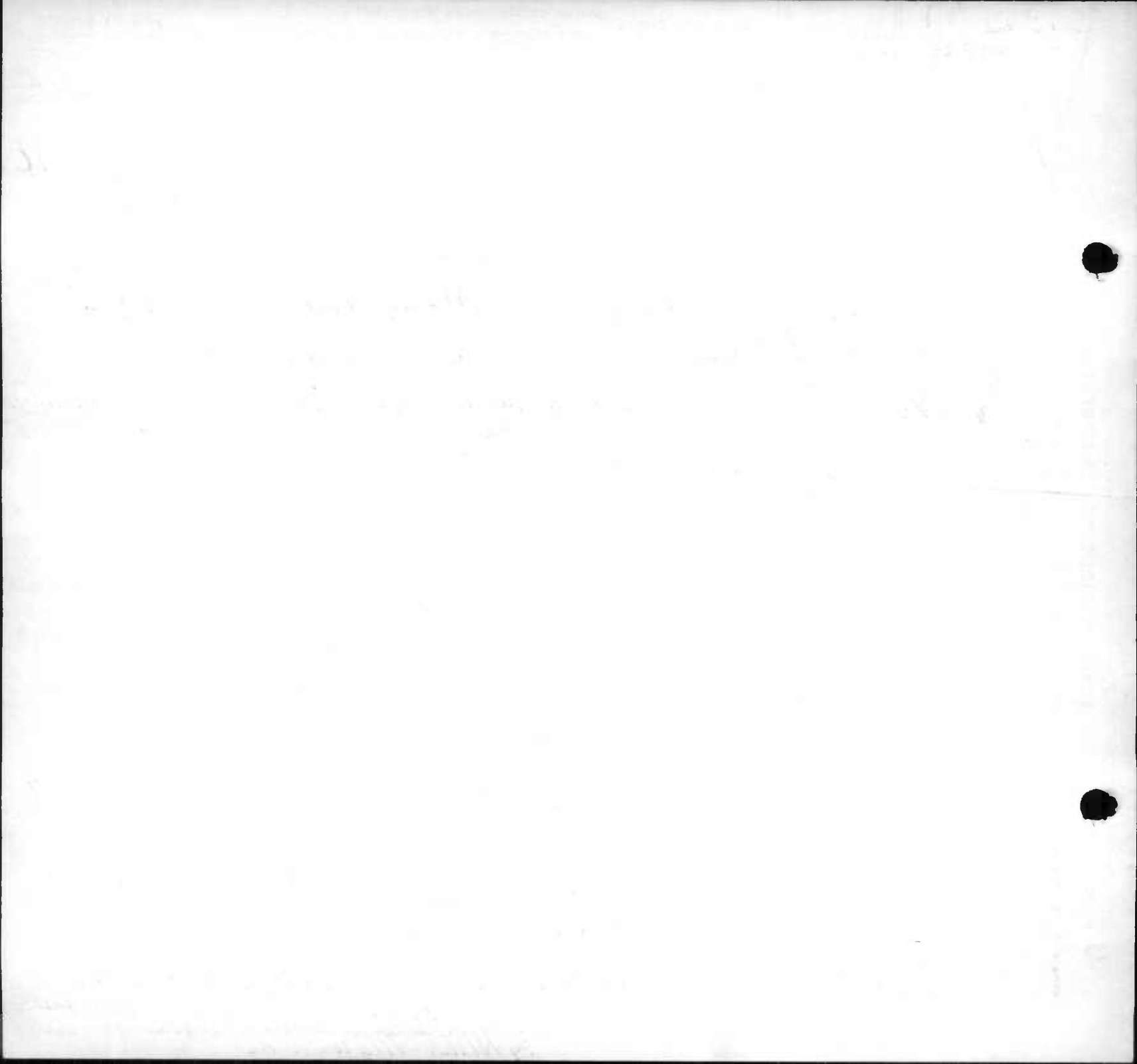




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11202				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11202	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MAE E. EVANS</b>				11-18-67 12:30 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
37 <b>MERCY HOSPITAL</b>				<b>MARYLAND</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				<b>BALTIMORE</b>			
				O. STREET ADDRESS (If rural, give location)			
				<b>315 W. LORRAINE AVE</b>			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	10. Under 24 Hrs. Ooys	10. Under 24 Hrs. Hours
<b>F</b>	<b>W</b>	<b>WIDOWED</b>	<b>3-4-00</b>	<b>67</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<b>CATERING WORKER</b>			<b>Food</b>		<b>Maryland</b>		<b>USA</b>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>Elijah Filmore</b>				<b>Wilhelmina Bradley</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS
<b>No</b>			<b>264 668 64</b>		<b>Mrs Marie Leister</b>		<b>315 W Lorraine Ave</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				<b>Kidney Failure</b>			
ANTECEDENT CAUSES				<b>Terminal Stage CA of the valve</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<b>NONE</b>				<b>Yes</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <b>7-1</b> 19 <b>67</b> to <b>11-18</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-18</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
<b>Leonardo A. Tridala</b>						<b>11-18-67</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
<b>LEONARDO A. TRIDALA</b>		<b>Mercy Hosp.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>11-21-67</b>		<b>Woodlawn Cem</b>		<b>Woodlawn Bk Co Md</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
<b>NOV 22 1967</b>		<b>Robert E. Farber</b>		<b>BURGEE</b>		<b>363 FALLS</b>	
by <b>William H. Morgan</b>							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 11203					CERTIFICATE OF DEATH			Registered No. 67 11203	
M.E. CASE NO.					DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <b>Wilt, Gratton Raymond</b>					11/18/67 12:58p. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>44 Union Memorial Hosp Baltimore</b>					A. STATE <b>Md.</b> B. COUNTY <b>Balt. City</b>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>				
D. STREET ADDRESS (If rural, give location) <b>1206 Union Ave</b>					13-08				
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>sep</b>		8. DATE OF BIRTH <b>08/12/68</b>		9. AGE (In years last birthday)		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>W. Virginia</b>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George L. Wilt</b>					14. MOTHER'S MAIDEN NAME <b>Mary Eliz. Grove</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>219033554</b>		17. INFORMANT <b>Sister</b>		
18. <b>163 X I</b>					CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					<b>Cardiac Resp. Arrest</b>				
ANTECEDENT CAUSES					<b>Ca of Lung - Disseminated</b>				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? Yes or No <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11/18/67</b> to <b>11/18/67</b> and that (I) (we) lost saw the deceased alive on <b>11/18/67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>B. J. Weckesser</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>11/18/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>B. J. Weckesser</b>					23D. ADDRESS <b>The Union Memorial Hospital Union Memorial Hosp.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>11-21-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Good Shepherd Cem</b>			24D. LOCATION (City, town, or county) (State) <b>Howard Co Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 22 1967</b>			25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>			25C. FUNERAL DIRECTOR <b>Burgess Funeral Home</b>			ADDRESS <b>3631 Falls Rd</b>

Ca of Lung - Pleurisy

George L. Wilt

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W. V. D.

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Cardiac Rep. Area

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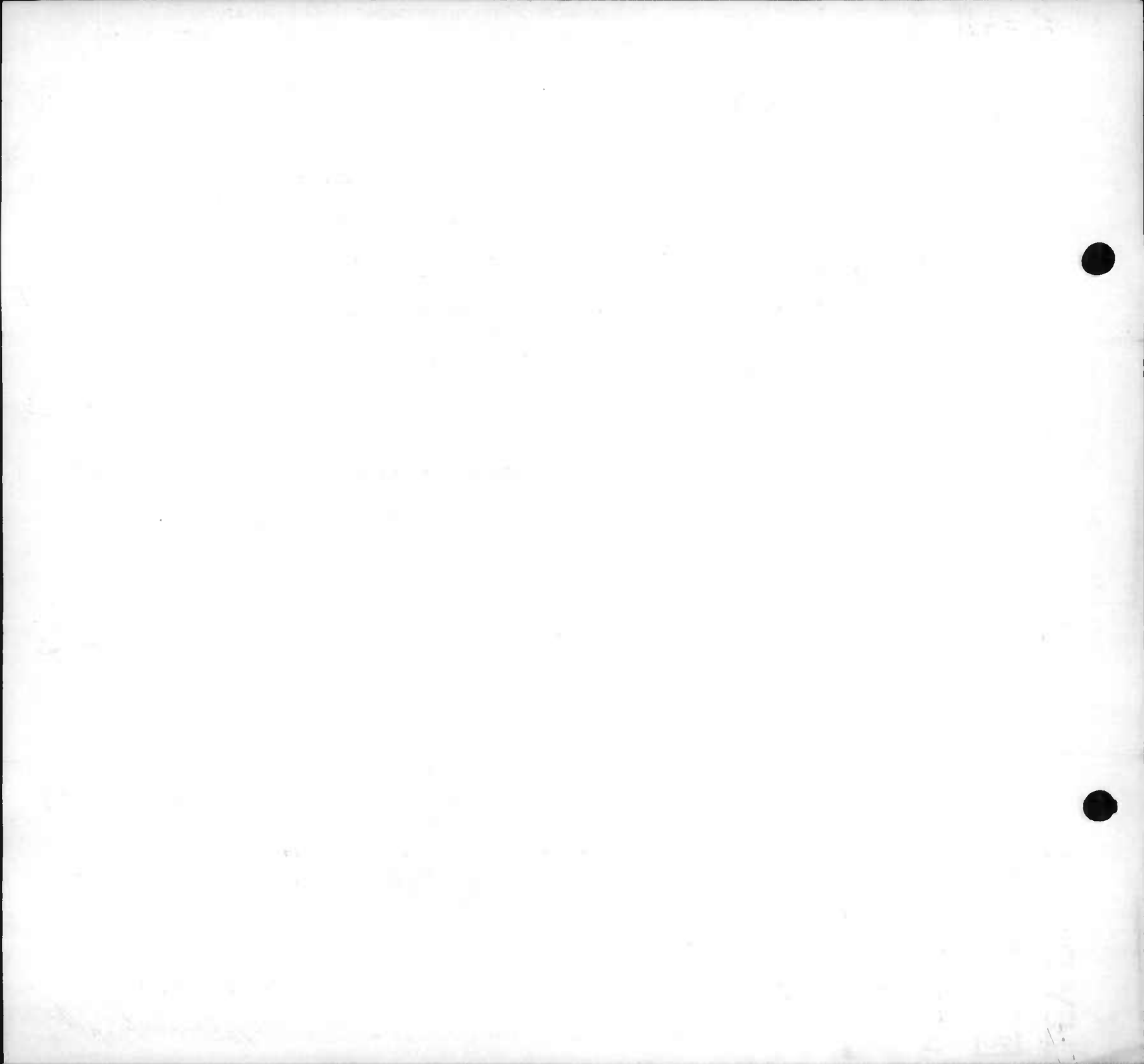
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clean the motor

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11204				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 259-414	
M.E. CASE NO. R.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Harvey Shindlecker				2. DATE AND HOUR OF DEATH 19 Nov 67 1 12 45 P.M.			
3. PLACE OF DEATH IN BALTIMORE/MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		USPHS Hospital		A. STATE Md. City		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26-36			
				D. STREET ADDRESS (If rural, give location) 6211 Danville Ave.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Mar.	8. DATE OF BIRTH 15 Aug 1890	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Army		10B. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Shindlecker				14. MOTHER'S MAIDEN NAME Sara Shriner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) Yes 1913 - 1944		16. SOCIAL SECURITY NO. 212-26-5229		17. INFORMANT wife - chart		ADDRESS AS block D	
18. 260 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(B) Diabetes mellitus years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASHD, CVA's X 2						2 months 3 weeks } CVA's	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8 September 19 67 to 19 Nov 19 67, that (I) (we) last saw the deceased alive on 19 Nov 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE W.G. Percott				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 19 Nov 67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D. USPHS Hospital Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/22/67		24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1967		25B. NAME OF REGISTRAR Robert E. Farber, MD		25C. FUNERAL DIRECTOR W. Brooks Bradley, Headlath, MD		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Registered No. 67 11205

Registered No. 67 11205

VS 150-REV. 1/1/65

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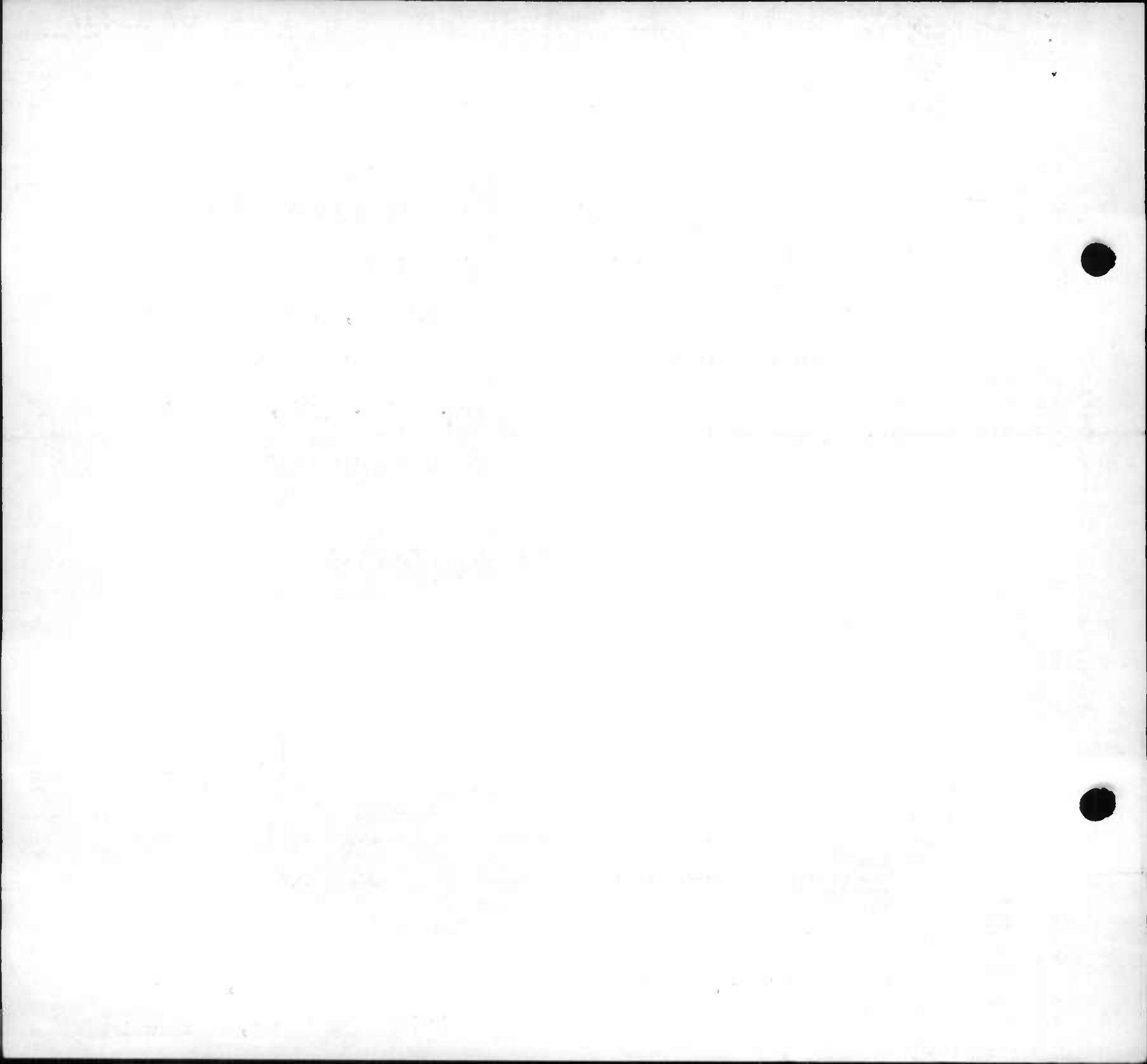
1. NAME OF DECEASED (Type or Print) <b>DAVID ALLEN THORNTON</b>			2. DATE AND HOUR PRONOUNCED DEAD <b>November 21, 1967 7:00 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Johns Hopkins Hospital (DOA)</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>4103 Balfern Avenue</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Never Married</b>	8. DATE OF BIRTH <b>October 29 1967</b>	9. AGE (In years last birthday) <b>21</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>James Thornton</b>			14. MOTHER'S MAIDEN NAME <b>Shirley Thornton</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT ADDRESS <b>James Thornton 4103 Balfern Avenue</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Interstitial Pneumonitis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>INTERSTITIAL PNEUMONITIS</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>11/21/67</b>					
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23B. DATE <b>Nov 22 67</b>	23C. NAME of CEMETERY or CREMATORY <b>Shiloh Cemetery</b>	23D. LOCATION (City, town, or county) (State) <b>Pulaski Virginia.</b>		
24A. DATE REC'D BY HEALTH DEPT. <b>NOV 22 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Farley</b>	24C. FUNERAL DIRECTOR ADDRESS <b>The Dippel Brothers Inc 7110 Belair Rd.</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">67 11207</span>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="float: right;">67 11207</span>	
M.E. CASE NO.		67 11207		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		MERKLE ROLAND		2. DATE AND HOUR OF DEATH 11-20-67 11-25 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) LINTHICUM 52-00	
FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL		D. STREET ADDRESS (If rural, give location) 918 WANDA Rd.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 24 May 1907	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Restauranteur		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME George Merkle		14. MOTHER'S MAIDEN NAME Lealer Perry		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Edna B. Merkle, same as 4	
18. 15301 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Co. of ascending colon (B) DUE TO (C) Pulmonary carcinoma INTERVAL BETWEEN ONSET AND DEATH months		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-15 1967 to 11-20 1967, that (I) (we) last saw the deceased alive on 11-20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Enrique Rafael		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11-20-67	
23C. PHYSICIAN'S NAME (Type) ENRIQUE RAFAEL		23D. ADDRESS M.D. LUTHERAN HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 24 Nov. 67		24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial	
24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland		25A. DATE REC'D BY HEALTH DEPT. NOV 22 1967		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-160		67 11208		BIRTH NO.		67 11208		CERTIFICATE OF DEATH		Registered No. 67 11208	
1. NAME OF DECEASED (Type or Print) <b>MARY A. SCHAEFER</b>						2. DATE AND HOUR OF DEATH <b>NOVEMBER 18/67 7:55 A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>36 FRANKLIN SQUARE HOSPITAL</b>						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND, BALTIMORE COUNTY</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>DUNDALK 53-00</b> D. STREET ADDRESS (If rural, give location) <b>6729 ROBERTS AVE. #22</b>					
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SINGLE</b>		8. DATE OF BIRTH <b>12/26/76</b>		9. AGE (In years last birthday) <b>90</b>		10. Under 1 Yr. Months: Days 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>HOUSE WORK</b>				11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN SCHAEFER</b>						14. MOTHER'S MAIDEN NAME <b>ADELHEID REUS</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates at service) <b>NO</b>				16. SOCIAL SECURITY NO. (1351A) <b>215-03-1631</b>		17. INFORMANT <b>FRANKLIN SQUARE HOSP.</b>				ADDRESS	
18. CAUSE OF DEATH <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>carcinomatous</b> <b>CVA</b> <b>CHF 5° to A.S.C.V.D. &amp; A.C.V.D.</b>  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>0</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 4, 1967</b> to <b>NOV. 18, 1967</b> , that (I) (we) last saw the deceased alive on <b>NOV. 18, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Ruben V. Luna</b>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>11-18-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>RUBEN V. LUNA</b>						23D. ADDRESS <b>FRANKLIN SQUARE HOSP.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11-22-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>SACRED HEART CEM.</b>				24D. LOCATION (City, town, or county) (State) <b>7401 GERMAN HILL RD. BALTO., MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 22 1967</b>				25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>				25C. FUNERAL DIRECTOR <b>Charles S. Zeiber</b>			
ADDRESS <b>901 S. CONKLING ST. BALTO., 21224, MD.</b>											

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Handwritten text, possibly a signature or date, including "1922" and "1923".

Handwritten text, possibly a name or title, including "C. J. ...".

Handwritten text, mostly illegible due to fading and bleed-through.

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
Certificate of Death					Registered No. 67 11209					
BIRTH NO. <u>5-538 67 11209</u>										
M.E. CASE NO.										
1. NAME OF DECEASED (Type or Print) <u>SMITH, Winifred Loretta</u>					2. DATE AND HOUR OF DEATH <u>6:40 PM 11-18-69</u> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 UNIVERSITY HOSPITAL</u>					A. STATE <u>PENNA</u>					
					B. COUNTY					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>HANOVER</u> <u>V-35</u>					
					D. STREET ADDRESS (If rural, give location) <u>RD 4</u>					
5. SEX <u>F</u>	6. RACE <u>W W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>6-1-97</u>	9. AGE (In years last birthday) <u>70</u>	10. Under 1 Yr. Months: Days:		11. Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife - Farmer</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>JOHN LIVESBERRY</u>					14. MOTHER'S MAIDEN NAME <u>JANE Lawrence</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>					16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>HELEN SMITH</u>			
					ADDRESS <u>RD 4 Hanover Pa</u>					
18. <u>416X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
					(A) <u>Cardio-pulmonary Arrest</u> DUE TO <u>40 min</u>					
			(B) <u>VENTRICULAR FIBRILLATION</u> DUE TO <u>40 min</u>							
			(C) <u>CHRONIC RHEUMATIC HEART DISEASE + CHRONIC CHF</u> DUE TO <u>years</u>							
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>William H. Parker</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>11/19/69</u>		
23C. PHYSICIAN'S NAME (Type) <u>WILLIAM H. PARKER</u> M.D.					23D. ADDRESS <u>UNIVERSITY HOSPITAL BALTO. MD</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>11-22-69</u>			24C. NAME OF CEMETERY or CREMATORY <u>CONEWAGO CHAPEL</u>			24D. LOCATION (City, town, or county) (State) <u>HANOVER CONEWAGO PA.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 22 1969</u>			25B. NAME OF REGISTRAR <u>Robert E. Faller</u>			25C. FUNERAL DIRECTOR <u>Harry J. Walter</u>				
						ADDRESS <u>McSherrystown Pa.</u>				

NAME

John Bull 2nd Grade Class  
Spent 5 hours in the library



FUNERAL DIRECTOR: IMPORTANT

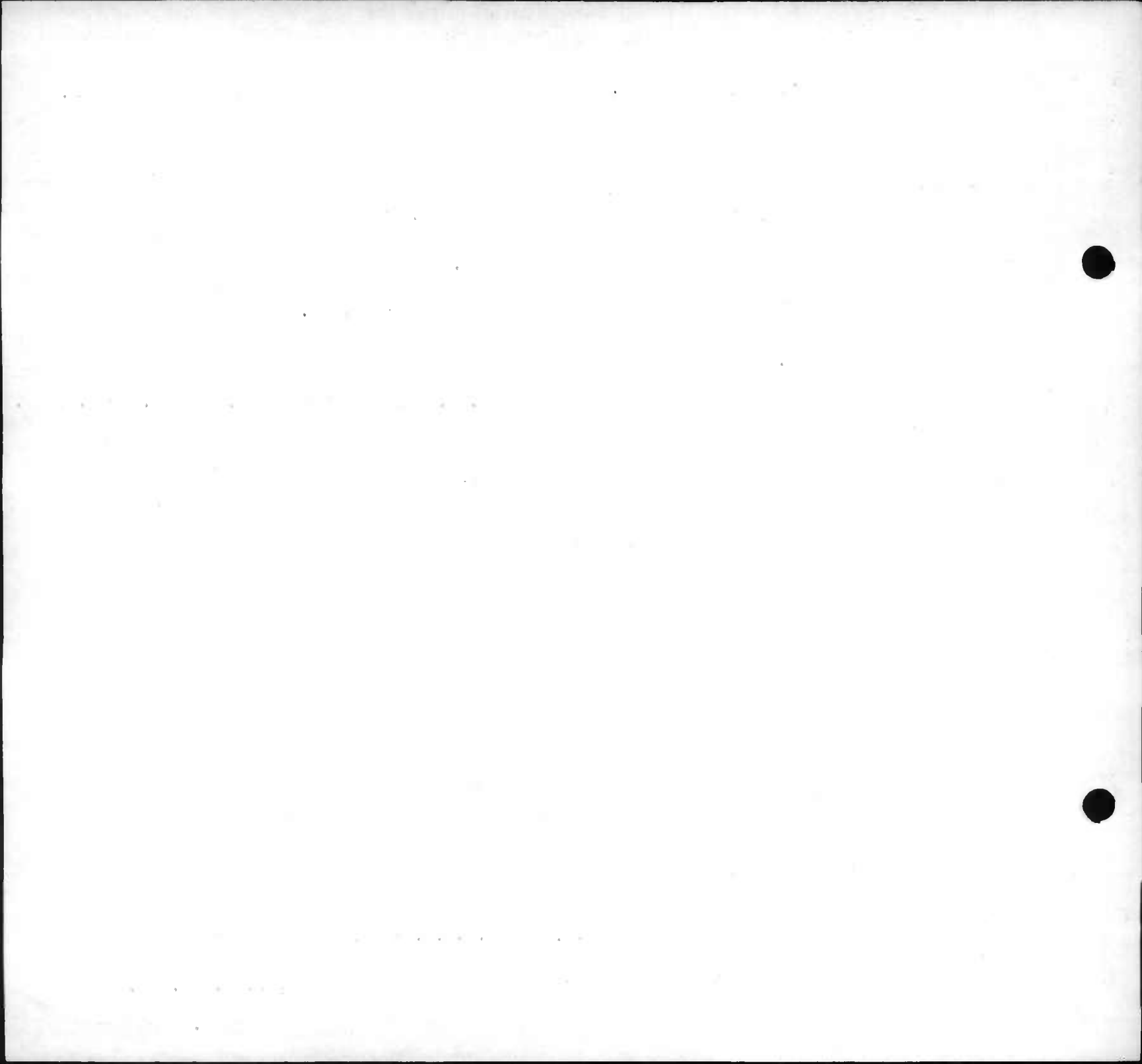
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11210		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11210	
BIRTH NO. <b>R-163</b>		67 11210		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED <b>CLARENCE E. ROBERTS Sr.</b>		2. DATE AND HOUR OF DEATH <b>16 Nov. 1967 1145 AM.</b>	
(Type or Print)		<b>CLARENCE ROBERTS</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSP</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore Co.</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE - Edgemere</b>			
		D. STREET ADDRESS (If rural, give location) <b>7409 North Point Rd.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>8-21-10</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Candler</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bike Steel</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Joseph Roberts</b>		14. MOTHER'S MAIDEN NAME <b>ESTELLE HISSEY</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-09-3715</b>		17. INFORMANT <b>Wife, Ellen Roberts, # 4, a, b, c, d.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Carcinoma of Large Intestine</b>			
ANTECEDENT CAUSES		(B) <b>Cervical Metastases</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <b>Common</b>			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <b>14 Nov 1967</b> to <b>16 Nov 1967</b> , that (I) (we) last saw the deceased alive on <b>16 Nov 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M.B. Flynn</b>		M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>16 Nov 67</b>	
23C. PHYSICIAN'S NAME (Type) <b>M.B. FLYNN</b>		23D. ADDRESS <b>Maryland General Hosp</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-20-1967</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(Note)			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 22 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-650		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11211	
BIRTH NO. 67 11211		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print)		11/21/67 2:55 a. M.			
John L. Greene Sr.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 43 SOUTH BALTIMORE GENERAL HOSPITAL		A. STATE Maryland B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 23-01			
		D. STREET ADDRESS (If rural, give location) 1432 S. Charles Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Feb. 12, 1900	9. AGE (In years last birthday) 67	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Warehouseman
		10B. KIND OF BUSINESS OR INDUSTRY Food Store	11. BIRTHPLACE (State or foreign country) Cambridge, Md.		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME John H. Greene		14. MOTHER'S MAIDEN NAME Julia Unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. J. Lawrence Greene Jr. 322 E. Univ. Pkwy.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 527.21 CHRONIC OBSTRUCTIVE AIRWAY DISEASE		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/19/67 to 11/21/67, that (we) last saw the deceased alive on 11/21/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (Yes) (did) (did not) view the body after death.					
23A. SIGNATURE Gerard D. Dobrzycki		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/21/67	
23C. PHYSICIAN'S NAME (Type) GERARD D. DOBRZYCKI, M.D.		23D. ADDRESS S.B.G.H. - 1213 Light Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11 24 67		24C. NAME of CEMETERY or CREMATORY Cedar Hill	
24D. LOCATION Brooklyn, A. A. Co. Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1967		25B. NAME OF REGISTRAR Robert E. Jarkyns		25C. FUNERAL DIRECTOR ADDRESS Mc Cully, 130 E. Fort Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
67 11212		67 11212		67 11212	
<b>CERTIFICATE OF DEATH</b>					
M.E. CASE NO.		2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print)		NOVEMBER 17 1967 8:45 P.M.			
MANDEL ROSE ELIZABETH					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
ST AGNES HOSPITAL		A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND			
CATON & WILKENS AVE		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
BALTO., MD. 21229		BALTIMORE			
		D. STREET ADDRESS (If rural, give location)			
		3147 STRICKLAND ST			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
FEMALE	WHITE	WIDOWED	6/3/01	66	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE				MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
GEORGE -HARMAN-		ESTELLA-LE BON-			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		219-18-1193		ST AGNES HOSPITAL RECORDS	
18. 3-8-70 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) acute pancreatitis			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from OCTOBER 30 19 67, to NOVEMBER 17 19 67, that (X) (we) last saw the deceased alive on NOVEMBER 17 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (XX) (We) (did) (not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Romualdo R. Dator				Nov. 18, 1967	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
ROMUALDO R. DATOR		CATON & WILKENS AVES., BALTO., MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		Nov. 21, 1967		Loudon Park Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 22 1967		G. Trueman Schwab		3512 Frederick Ave. Balto. Md.	

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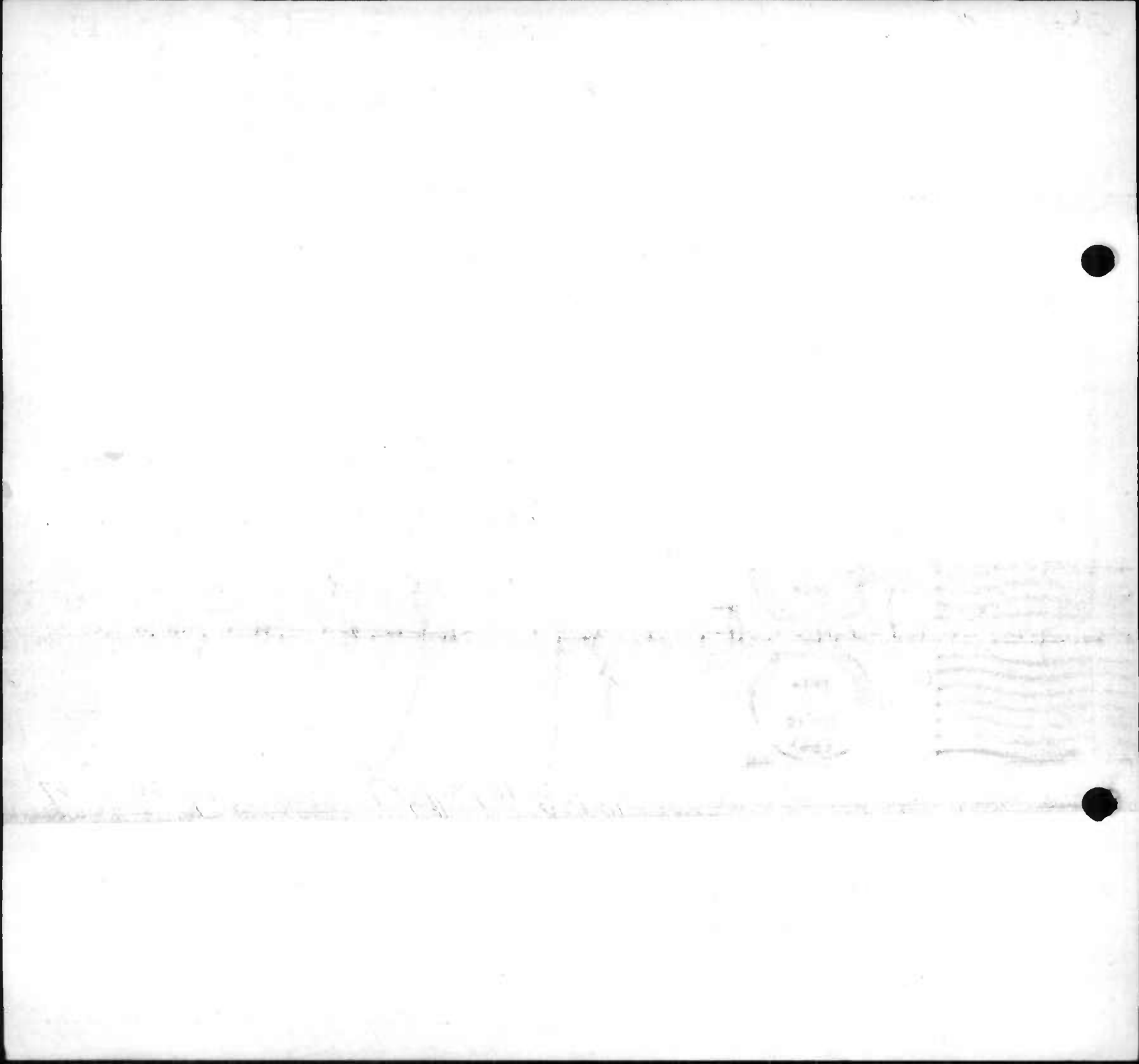
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11213				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 11213	
1. NAME OF DECEASED (Type or Print) <b>CONCETTA, VINCENZA GOLDSTRAW</b>				2. DATE AND HOUR OF DEATH <b>11/20/67 10:45 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>FRANKLIN SQUARE HOSP 36</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1001 RENICK COURT BROOKLYN</b>					
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>2/9/02</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>VINCENT BRACKETTO</b>				14. MOTHER'S MAIDEN NAME <b>AUGUSTA DRUSCHHELL</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>ESTELLA E. DAVIS (DAUGHTER)</b>					
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b>				CAUSE OF DEATH (A) DUE TO <b>Infection of Gall-Bladder region for 1 wks.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>10/31/67</b> to <b>11/20/67</b> , that (I) (we) last saw the deceased alive on <b>10/20/67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Thomas A. Alvero</b>				23B. DATE SIGNED <b>11/20/67</b>					
23C. PHYSICIAN'S NAME (Type) <b>TOMAS A. ALVERO</b>				23D. ADDRESS <b>FRANKLIN SQUARE HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-24-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 22 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>McCully</b>		ADDRESS <b>130 E. Fort Ave.</b>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BIRTH NO. 67 11214		67 11214		CITY HEALTH DEPARTMENT		Registered No. 67 11214	
1. NAME OF DECEASED (Type or Print) <b>Baby Boy Brown</b>				2. DATE AND HOUR OF DEATH <b>20 November 1967 8:45 PM.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>Johns Hopkins Hospital</b> (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1002 Hillman Street</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Never Married</b>	8. DATE OF BIRTH <b>25 Oct., 1967</b>	9. AGE (In years last birthday) <b>26</b>	10. Under 1 Yr. Months <b>26</b>	11. Under 24 Hrs. Days <b>21</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>infant</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Albert Matthews</b>				14. MOTHER'S MAIDEN NAME <b>Jacqueline Brown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hyaline Membrane Disease</b>				CAUSE OF DEATH (A) <b>Hyaline Membrane Disease</b> (B) <b>Respiratory Failure</b> (C) <b>Recurrent Pneumonitis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>26 days</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>25 October 19 67</b> to <b>20 November 19 67</b> , that (I) (we) last saw the deceased alive on <b>20 November 19 67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ( <u>did</u> ) (did not) view the body after death.							
23A. SIGNATURE <b>Martin G. Myers</b> M.D.				23B. DATE SIGNED <b>20 November, 1967</b>		23C. PHYSICIAN'S NAME (Type) <b>Martin G. Myers</b>	
23D. ADDRESS <b>Johns Hopkins Hospital</b> M.D.				23E. ADDRESS <b>Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>		24B. DATE <b>11-21-67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>JOHNS HOPKINS HOSPITAL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>NOV 22 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>HOSPITAL DISPOSAL</b>		25D. ADDRESS	

Johns Hopkins Hospital

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-200		67 11215		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11215	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>IRENE AGNES MIX</u>				Nov. 21, 1967 6:45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>2110 PENROSE AVE</u>				A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside, city limits, write RURAL and give township) <u>20-02</u> D. STREET ADDRESS (If rural, give location) <u>2110 PENROSE AVE</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JAN. 4, 1891</u>	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE ADAMS</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-05-5935</u>		17. INFORMANT <u>LILLIAN BEADEN ROPT</u>		ADDRESS <u>309 S. PULASKI ST</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>443X I</u>				CAUSE OF DEATH (A) <u>Alcohol related CVD</u> (B) <u>Due to</u> (C) <u>Due to</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<u>Hypertensive CVD</u>		<u>10 yrs.</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 13</u> 19 <u>67</u> to <u>Nov 21</u> 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Nov 13</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>11-21-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>				23D. ADDRESS <u>6014 Edmonson Ave.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11-25-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>LONDON PARK</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD</u>	
25A. DATE RECD. BY HEALTH DEPT. <u>NOV 22 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairburn</u>		25C. FUNERAL DIRECTOR <u>GEORGE L. SCHWAB GENERAL HOME</u>		ADDRESS <u>Francis A. Miller 210, Frederick Ave.</u>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11216		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11216	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LOUISE WEITZEL WEIKEL		2. DATE AND HOUR OF DEATH 11-20-67	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 LONG GREEN NURSING HOME 115 E. MELROSE AVE.		A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2303 PENTLAND DRIVE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12-14-1882	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHARLES FREDERICK		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-32-1434		17. INFORMANT ADDRESS Mrs. Helen Case - 2303 Pentland Drive	
18. 450.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Transition DUE TO (B) Generalized atherosclerosis DUE TO (C) Reactive depression		INTERVAL BETWEEN ONSET AND DEATH 18 months " "	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 19 66 to Nov 19 67, that (I) (we) last saw the deceased alive on Nov 16 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Louis H Schaffer		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/21/67	
23C. PHYSICIAN'S NAME (Type) Louis H Schaffer		23D. ADDRESS M.D. 222 W Coed Spring Lane Baltimore, Md 21210			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-22-67		24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTO., MD.		25A. DATE REC'D BY HEALTH DEPT. NOV 22 1967			
25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS Gertie Hill - 2334 Jefferson St.			

2015-2016

2015-2016

2015-2016

2015-2016

2015-2016

2015-2016

2015-2016

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

THIS CASE RELEASED ON APPROVAL BY DR. WILSON OF THE MEDICAL EXAMINER'S OFFICE

BIRTH NO. 67 11217		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11217	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
HERMAN H. HALL		11-20-67 3:10 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE NEW YORK			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) JOHNSTOWN			
33 THE JOHNS HOPKINS HOSPITAL		D. STREET ADDRESS (If rural, give location) 307 W. MAIN ST.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-11-18	9. AGE (In years lost birthday) 49	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER		10B. KIND OF BUSINESS OR INDUSTRY filling Station		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME HERMAN HALL			14. MOTHER'S MAIDEN NAME EDITH SLEEZER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 076-03-4146		17. INFORMANT ADDRESS Barter Funeral Home, Johnstown, N.Y.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19. CAUSE OF DEATH Heart Failure Vent. Fibrillation Irregular Myocardium 2° Aortic Stenosis		INTERVAL BETWEEN ONSET AND DEATH onset (Deed) 30 min	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 11/20/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Infected Pacemaker Wires		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/18 1967 to 11/20 1967, that (I) (we) lost saw the deceased alive on 11/20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard N. Scott				23B. DATE SIGNED 11/20/67	
23C. PHYSICIAN'S NAME (Type) RICHARD N. SCOTT				23D. ADDRESS The Johns Hopkins Hosp. (Balto. Md.)	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE NOV 22 1967		24C. NAME OF CEMETERY or CREMATORY Evergreen	
24D. LOCATION Fonda, N.Y.					
25A. DATE REC'D BY HEALTH DEPT. 11/20/67		25B. NAME OF REGISTRAR Robert E. Bailey, M.D.		25C. FUNERAL DIRECTOR ADDRESS Balto., Md. Wm. Cook-Brooks, Inc., 1217 St. Paul St.	

0

or 

or

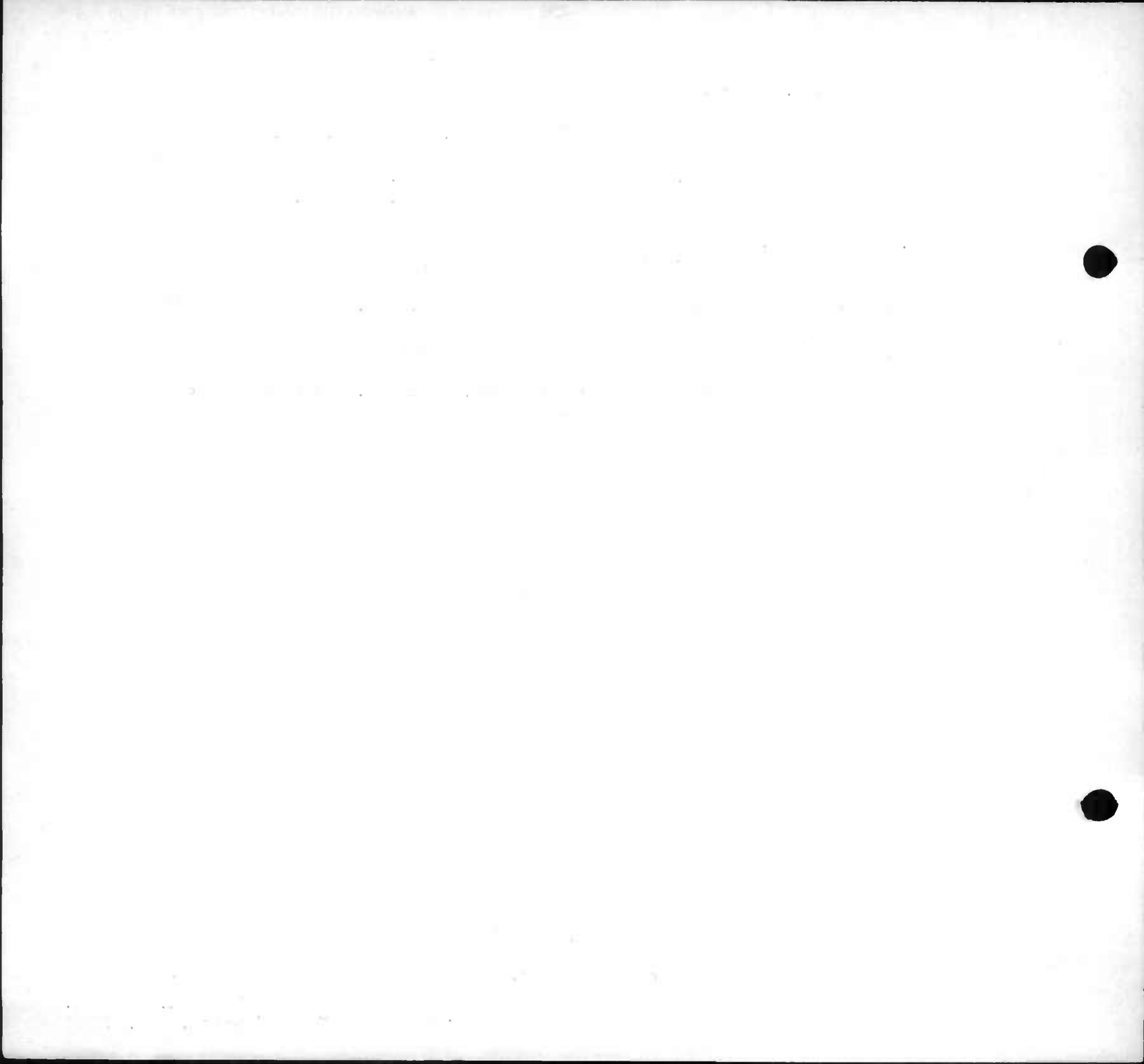
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10/20/11  
12/12/11 9 call intelligible and att



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11218</b>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <b>67 11218</b></span> <span>CERTIFICATE OF DEATH</span> </div>					
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>Blanche K. Olszewski</b>			<b>2. DATE AND HOUR OF DEATH</b> <b>11-21-1967</b> <span style="float: right;">1 P. M.</span>		
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1725 St Paul St.</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balto., Md.</b> <b>5. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <b>Balto.</b> <b>6. STREET ADDRESS</b> (If rural, give location) <b>1725 St. Paul St.</b>		
<b>5. SEX</b> <b>F.</b>	<b>6. RACE</b> <b>Cau.</b>	<b>7. MARRIED, NEVER MARRIED</b> <b>WIDOWED, DIVORCED (specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>1-26-1909</b>	<b>9. AGE</b> (In years last birthday) <b>58</b>	<b>If Under 1 Yr. Months: Days</b> <b>If Under 24 Hrs. Hours: Min.</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> -----	<b>11. BIRTHPLACE</b> (State or foreign country) <b>Balto., Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>
<b>13. FATHER'S NAME</b> <b>Ephmaw Dill</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Katie Dill</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>212-14-1627</b>	<b>17. INFORMANT</b> <span style="float: right;">ADDRESS</span> <b>Mr. Martin H. Olszewski</b> <span style="float: right;">Same as Above</span>		
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>(A) DUE TO</b> <i>Coronary Artery Disease</i> <b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>1 day</i> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ----- <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. -----					
<b>19A. DATE OF OPERATION</b> <i>None</i>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <i>None</i>	<b>20A. AUTOPSY?</b> (Yes or No) <b>NO</b>	<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) -----	<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) -----		
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.) -----		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	<b>21F. HOW DID INJURY OCCUR?</b> -----		
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>Nov. 20</i> <b>1967</b> <b>to</b> <i>Nov. 24</i> <b>1967</b> , that (I) (we) last saw the deceased alive on <i>Nov. 24</i> <b>1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
<b>23A. SIGNATURE</b> <i>Frank N. Ogden</i>				<b>23B. DATE SIGNED</b> <b>Nov. 22, 1967</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>FRANK N. OGDEN, M.D.</b>			<b>23D. ADDRESS</b> <b>2701 N. Calvert St Baltimore Md.</b>		
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>24B. DATE</b> <b>11-24-1967</b>	<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Meadowridge Me. Park</b>	<b>24D. LOCATION</b> (City, town, or county) (State) <b>Howard County, Md.</b> <span style="float: right;"><b>21218</b></span>		
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>NOV 22 1967</b>		<b>25B. NAME OF REGISTRAR</b> <i>Robert E. Finkbeiner</i>	<b>25C. FUNERAL DIRECTOR</b> <span style="float: right;">ADDRESS</span> <b>Wm. Cook-Brooks, Inc.</b> <span style="float: right;"><b>1217 St. Paul St. Balto., Md. 21202</b></span>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CORNELIUS ZAAL

2. DATE AND HOUR OF DEATH

NOVEMBER 21/67 9:55 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

MARYLAND GENERAL HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE 21229

D. STREET ADDRESS (If rural, give location)

1101 ST. PAUL ST.

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

9/27/95

9. AGE (In years  
last birthday)

72

If Under 1 Yr.  
Months: Days:

If Under 24 Hrs.  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

MERCHANT MARINE

10B. KIND OF BUSINESS OR INDUSTRY

Shipping

11. BIRTHPLACE (State or foreign country)

HOLLAND

12. CITIZEN OF  
WHAT COUNTRY?

HOLLAND

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

218-26-1539

17. INFORMANT

MELVA ZAAL (WIFE)

ADDRESS

SAME

18. 451 X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Ruptured Abdominal Aortic Aneurysm

(B) Atherosclerosis

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/21 1967 to 11/21 1967. that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Artemio M. Cuevas, Jr.

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11/22/67

23C. PHYSICIAN'S NAME (Type)

ARTEMIO M. CUEVAS, JR. M.D.

23D. ADDRESS

Maryland General Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/24/1967

24C. NAME OF CEMETERY or CREMATORY

Woodlawn Cem

24D. LOCATION

(City, town, or county)

Balto. County Md.

(State)

25A. DATE RECEIVED BY HEALTH DEPT.

NOV 22 1967

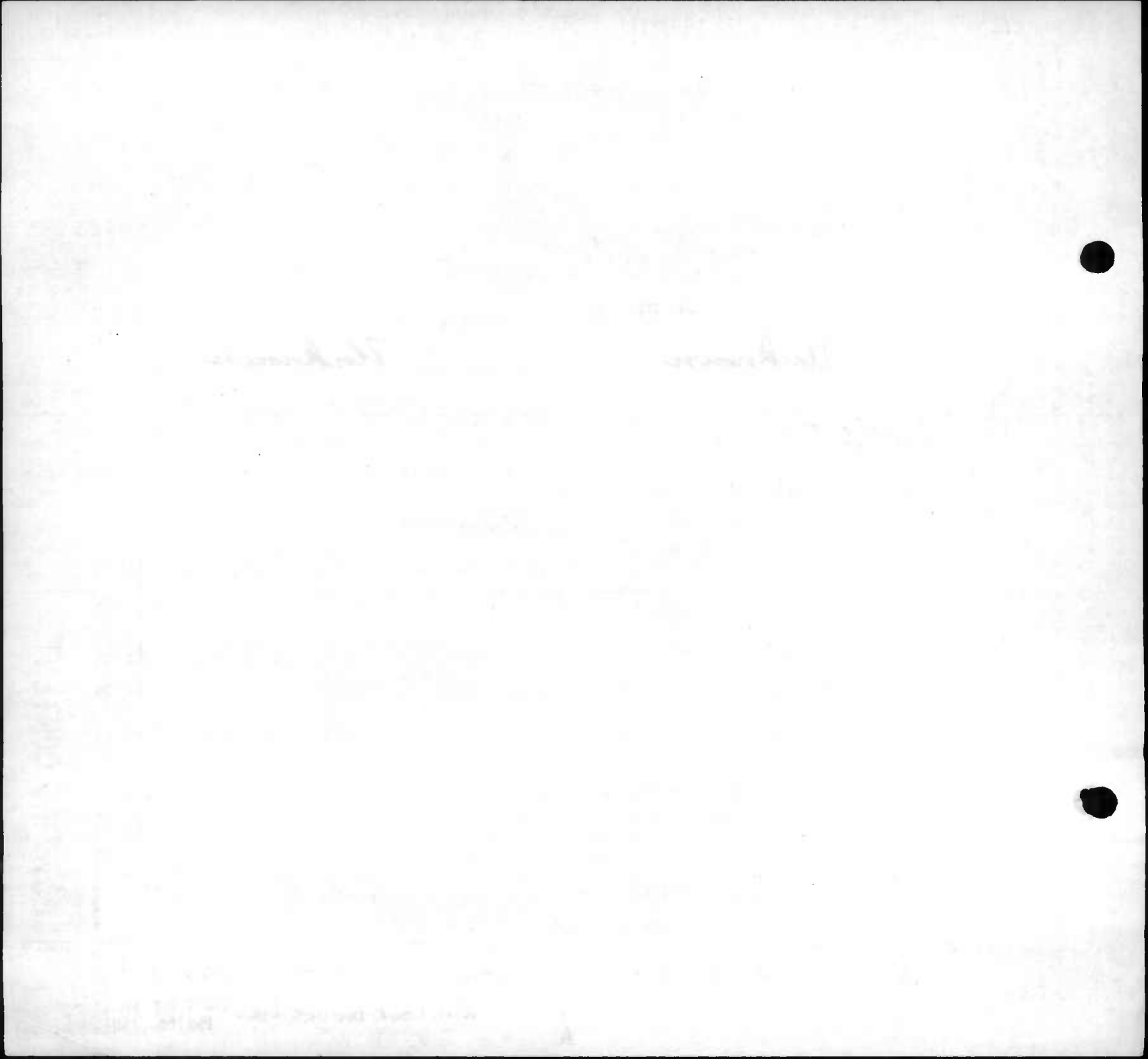
25B. NAME OF REGISTRAR

Robert E. Fairbank

25C. FUNERAL DIRECTOR

Wm. Cook-Brooks, Inc. 1217 St. Paul St. Balto., Md. 21202

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-2310

67 11220

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 67 11220

BIRTH NO. M.E. CASE NO.		67 11220		2. DATE AND HOUR OF DEATH November 19, 1967 1:40 P.M.	
1. NAME OF DECEASED (Type or Print) KATIE <del>XXXXXXXX</del> HACKETT					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harford Gardens Convalescent Home 4700 Harford Road		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) Blackstone Apts. (Charles & 33rd St.)			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Oct. 12, 1881	9. AGE (In years last birthday) 86	10. If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles Roehner		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT James E. Hackett 6201 Loch Raven Blvd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO acute myocardial infarction (B) DUE TO HACVD (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH sudden 3 years	
19A. DATE OF OPERATION 11/20/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture hip		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Bedroom		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Blackstone Apts Balto 18	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? Turned to use a new chair, chair slid away & fell to ground (floor)	
22. I certify that (I) (this hospital) attended the deceased from 11/17/67 to 11/17/67 and that (I) (we) last saw the deceased alive on 11/17/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Newland E. Day		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED November 20, 1967	
23C. PHYSICIAN'S NAME (Type) Newland E. Day		23D. ADDRESS M.D. 4 East 33rd Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-22-67		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Mem. Gardens	
24D. LOCATION Cockeysville		24E. LOCATION (City, town, or county)		24F. LOCATION (State) Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson Inc. 1050 York Rd. Towson, Md.	

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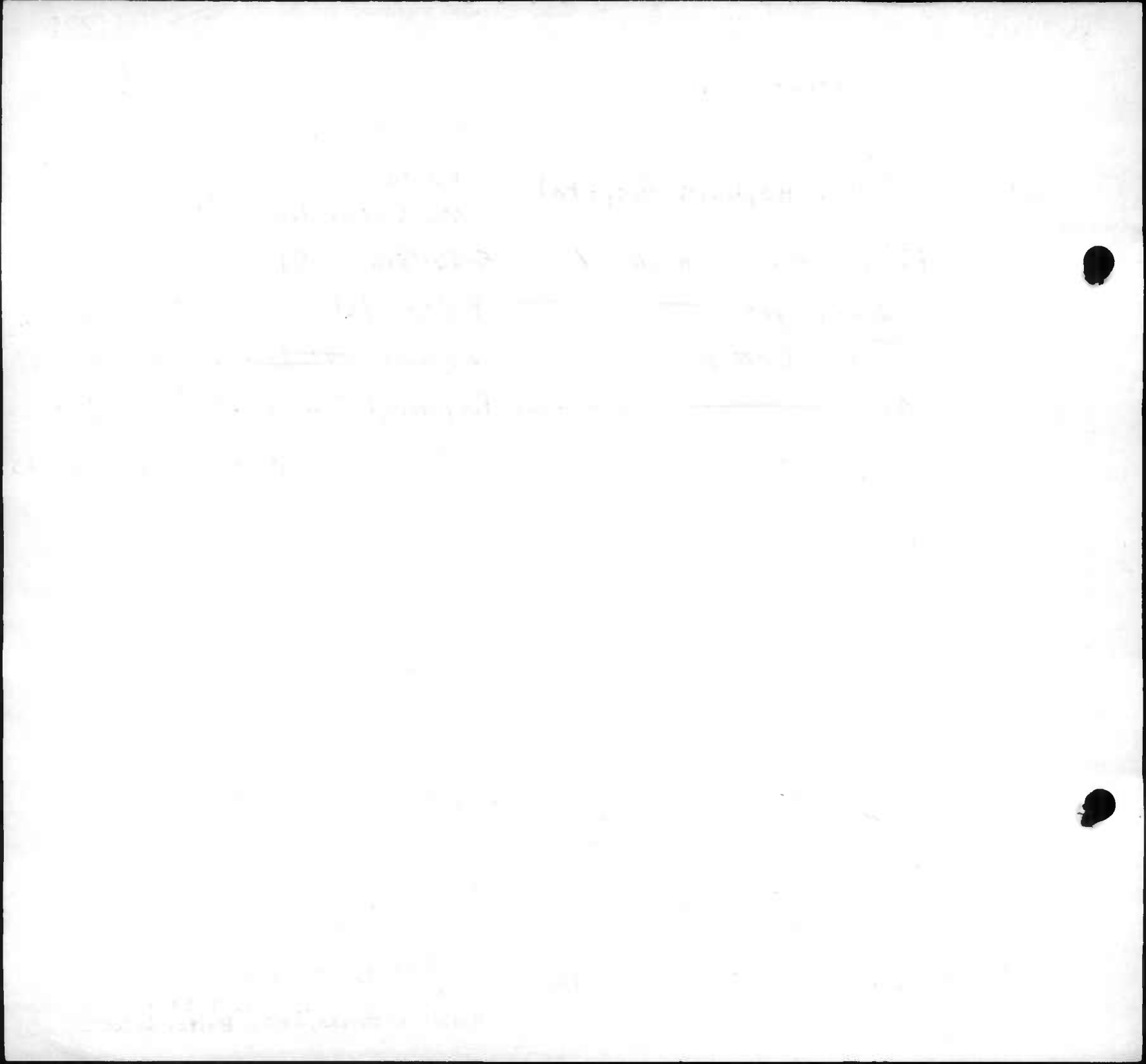
Partnership

Partnership

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 11221</u>	
67 11221				CERTIFICATE OF DEATH	
BIRTH NO. <u>67 11221</u>				M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <u>Agnes Theresa Baehr</u>				2. DATE AND HOUR OF DEATH <u>11/19/67</u> <u>4:30 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>33 John Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>(City)</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto.</u> D. STREET ADDRESS (If rural, give location) <u>900 Cathedral St.</u>	
5. SEX <u>Female</u>	6. RACE <u>Cau</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>5-26-1876</u>	9. AGE (in years last birthday) <u>91</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None for yrs.</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>John Cotton</u>		
14. MOTHER'S MAIDEN NAME <u>Laura (Unknown)</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>213-28-4023</u>			17. INFORMANT <u>Raymond C. A. Purl</u> ADDRESS <u>Union Carbide Co. Tokyo, Japan</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic heart disease known 3 weeks</u>				INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) <u>this hospital</u> attended the deceased from <u>10/14/67</u> 19 to <u>11/19/67</u> 19, that (1) <u>lost</u> saw the deceased alive on <u>11/18/67</u> 19 and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>did not</u> view the body after death.					
23A. SIGNATURE <u>W.B. Daniels, Jr.</u>				23B. DATE SIGNED <u>11/21/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>W.B. DANIELS Jr.</u>				23D. ADDRESS <u>11 E. Chase St., Balto. 21202</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>cremation</u>		24B. DATE <u>11/22/1967</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenmount Crematory</u>	
24D. LOCATION (City, town, or county) <u>Balto., Md.</u>		24E. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		24F. FUNERAL DIRECTOR <u>Wm. Cook-Brooks, Inc.</u>	
24G. DATE REC'D BY HEALTH DEPT. <u>NOV 22 1967</u>		24H. ADDRESS <u>1217 St. Paul St., Balto. 21202</u>			

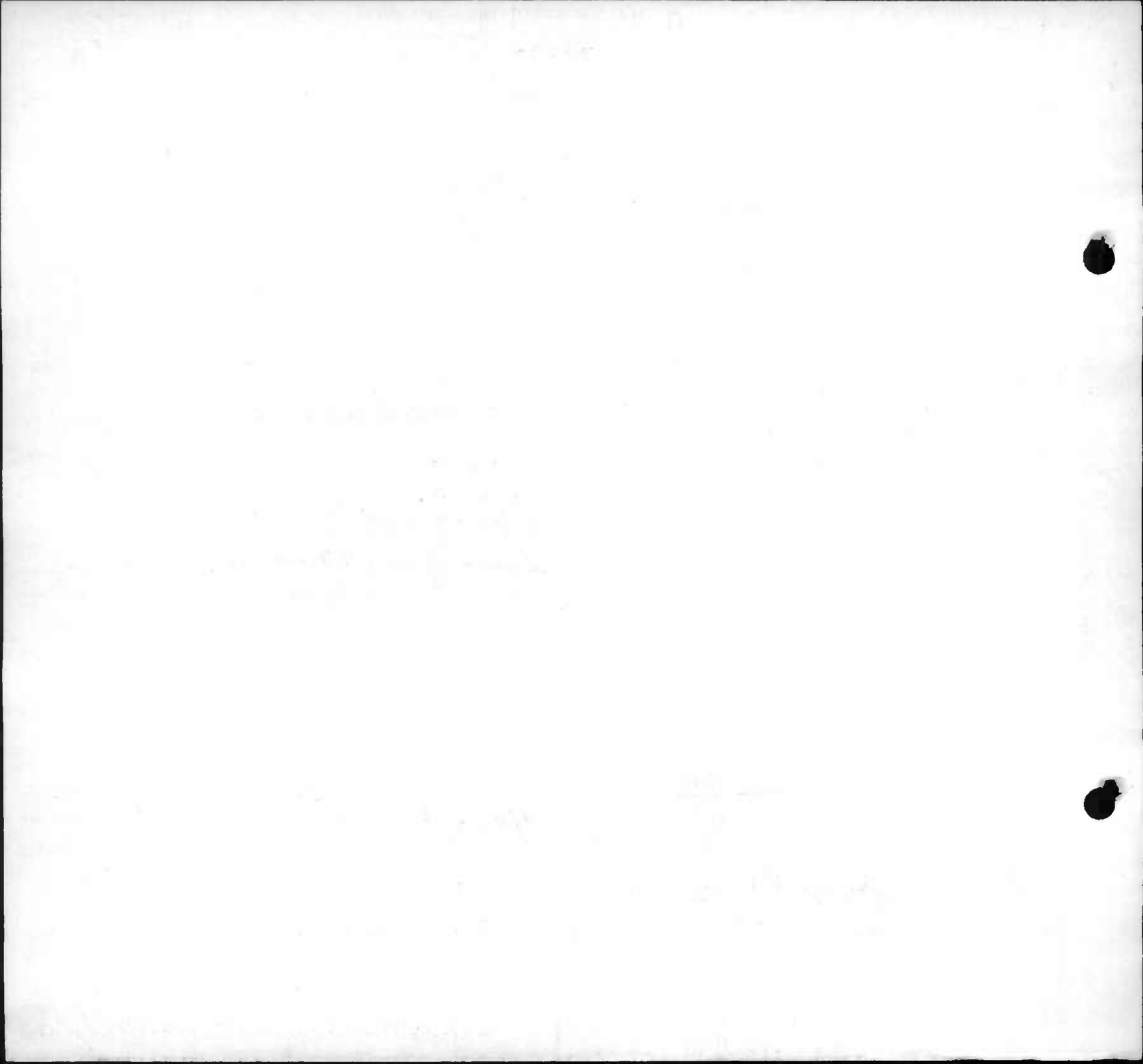




FUNERAL DIRECTOR: IMPORTANT

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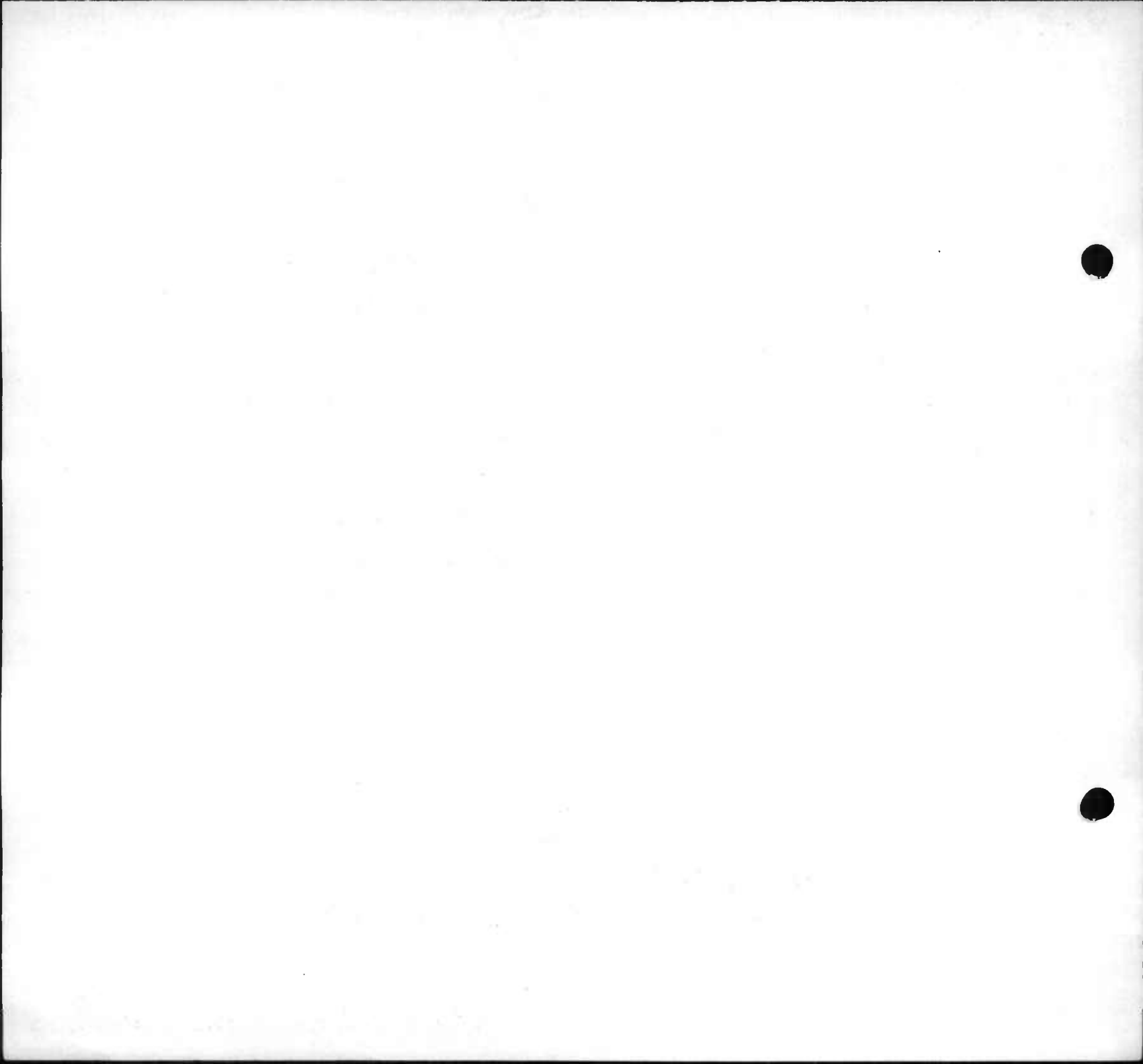
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 11222</u>	
BIRTH NO. <u>67 11222</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Stephen P. Novak</u>		2. DATE AND HOUR OF DEATH <u>11-20-67</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>35 Church Home and Hospital</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>4112 Elderon Ave</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>6-16-1904</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plant Operator</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto</u>	
13. FATHER'S NAME <u>Peter Novak</u>		14. MOTHER'S MAIDEN NAME <u>Tina Hudzik</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-05-6147</u>		17. INFORMANT ADDRESS <u>Jane Novak - Same</u>	
18. <u>422-11-029 X</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>C. V. A.</u> DUE TO <u>ASCVD.</u> (B) <u>Congestive Heart Failure</u> DUE TO (C) <u>Lues - (quiescent many years)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>SVODEN</u> <u>9 YRS.</u> <u>MORE THAN 15 YRS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/11</u> 19 <u>67</u> to <u>11/11</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/11</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>George Sharfatz M.D.</u>				23B. DATE SIGNED <u>11/21/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>GEORGE SHARFATZ</u>		23D. ADDRESS <u>6400 PARK HEIGHTS AVE BALTO MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11-22-67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 22 1967</u>			
25B. NAME OF REGISTRAR <u>Robert S. Johnson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>ELSWORTH ARMAROST-4600 Liberty Rd</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>67 11223</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>67 11223</b>	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>Thomas Howard Peters</b>			2. DATE AND HOUR OF DEATH <b>11-21-67</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 3112 Brightwood Ave</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>28 02</b> D. STREET ADDRESS (If rural, give location) <b>3112 Brightwood Ave</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>6-25-1902</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>LAUREL, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Allen Peters</b>			14. MOTHER'S MAIDEN NAME <b>Alice Hoffman</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-03-0602</b>	17. INFORMANT ADDRESS <b>Catherine R.G. Peters - Same</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>260X I</b>			CAUSE OF DEATH (A) DUE TO <b>Cerebral Vascular Disease</b> (B) DUE TO <b>Hypertension CVD</b> (C) DUE TO <b>Diabetes Mellitus</b>		
INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 19 60</b> to <b>11-21 1967</b> , that (I) (we) last saw the deceased alive on <b>11-22 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <b>5:30 AM</b>					
23A. SIGNATURE <b>Thomas G. Abbott</b> M.D.				23B. DATE SIGNED <b>11-21-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Thomas G. Abbott</b> M.D.				23D. ADDRESS <b>4509 Liberty Heights Ave</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11-24-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>St Louis Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Charmville, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 22 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, MA</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Elsworth Armacost - 4600 Liberty Heights</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		67 11224		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		67 11224	
M.E. CASE NO.				CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)				PETTERSON GUSTAV		2. DATE AND HOUR OF DEATH		11-21-67 5:45 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY		MD	
35 Church Home & Hospital						C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE 203	
						D. STREET ADDRESS (If rural, give location)		817 S. ANN ST	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
M	W	M	3-25-90	77					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
MARINER			—		SWEDEN		USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME						
?			?						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
?			223-10-6159		FRANCES PETTERSON				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH			
420.1 + 163X			Myocardial Infarction			6 hours.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO			?			
			(B) DUE TO			1 WEEK			
			(C) DUE TO						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CA, lung, Left						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Only medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 11-6-67 to 11-21-67, that (I) (we) lost saw the deceased alive on 11-21-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Dr. Otto Brantigan				11-21-67					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
Dr. Otto Brantigan				CH & H					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
BURIAL		11-24-67		ST. STANISLAUS		BALTIMORE MD			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
NOV 22 1967		Robert E. Farley, M.D.		George A. Weber		705 S. ANN ST			

Church Home & Hospital

M W

Mariner?

?

1833-30-1124

James Peterson

Myocardial Infarction

Atherosclerosis

Normal

CA, lung, left

\_\_\_\_\_

\_\_\_\_\_

11-21-11 11-21-11 11-21-11

Dr Otto Rosenberg

CH x H

11-21-11 11-21-11 11-21-11

11-21-11

11-21-11

Baltimore  
817 E. Ave B

3-22-10 33

Sweden  
?

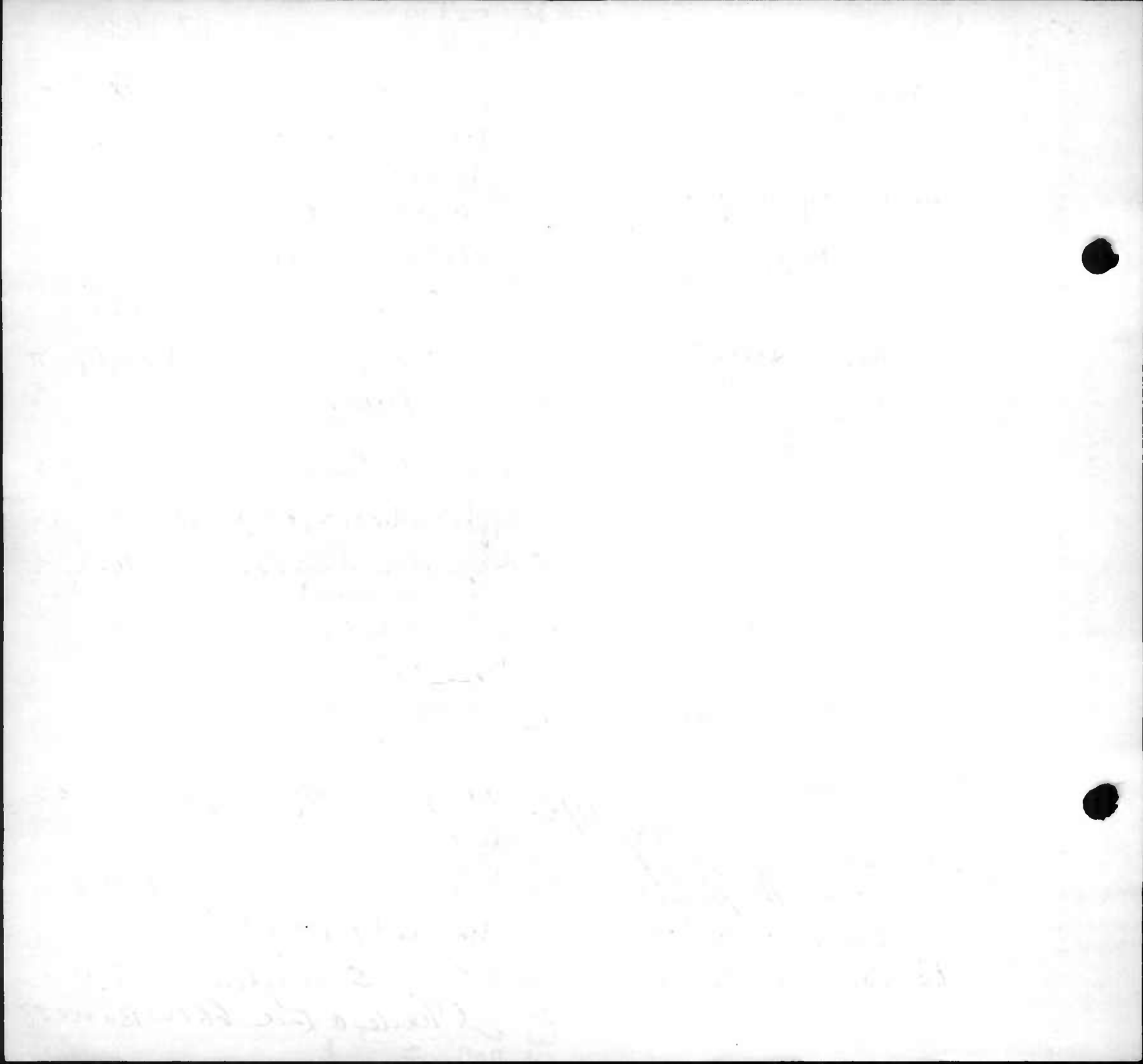
124

140

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																					
67 11225					CERTIFICATE OF DEATH					Registered No. 67 11225											
BIRTH NO.										DATE AND HOUR OF DEATH											
M.E. CASE NO.										11/20/67 8:05 AM											
1. NAME OF DECEASED (Type or Print)										2. DATE AND HOUR OF DEATH											
Henry Jones																					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)											
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)										A. STATE B. COUNTY											
University Hospital										Md. Balto. 1001											
										C. CITY OR TOWN (If outside city limits, write RURAL and give township)											
										Balto.											
										D. STREET ADDRESS (If rural, give location)											
										620 East Eager St											
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.									
Male		Negro				9/1/51		16													
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?									
								S. Carolina				USA									
13. FATHER'S NAME										14. MOTHER'S MAIDEN NAME											
Bossie Jones										Mary Stokes 620 E Eager St											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)										16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
No												Mother									
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										CAUSE OF DEATH											
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)										(A) DUE TO											
										Bilateral Pneumonia 16 yrs											
ANTECEDENT CAUSES										(B) DUE TO											
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										Kyphoscoliosis, rib deformity 16 yrs											
										(C) Osteogenesis Imperfecta 16 yrs											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										Mental retardation											
19A. DATE OF OPERATION										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED											
20A. AUTOPSY? (Yes or No)										20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
No																					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)											
No																					
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)										21D. TIME OF INJURY (Approx.)											
21E. INJURY OCCURRED										21F. HOW DID INJURY OCCUR?											
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>																					
22. I certify that (1) (this hospital) attended the deceased from 11/18 to 11/20 1967, that (1) (we) last saw the deceased alive on 11/20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.																					
23A. SIGNATURE										23B. DATE SIGNED											
Louis W. Miller										11/20/67											
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS											
Louis W. Miller										University Hospital											
24A. BURIAL CREMATION, REMOVAL (Specify)										24B. DATE											
Burial										11/25/67											
24C. NAME OF CEMETERY or CREMATORY										24D. LOCATION (City, town, or county) (State)											
Liberty Hill										Summerton S.C.											
25A. DATE REC'D BY HEALTH DEPT.										25B. NAME OF REGISTRAR											
NOV 22 1967										Robert E. Taylor											
25C. FUNERAL DIRECTOR										25D. ADDRESS											
Charles A. Rice										661 W. Barnes St											

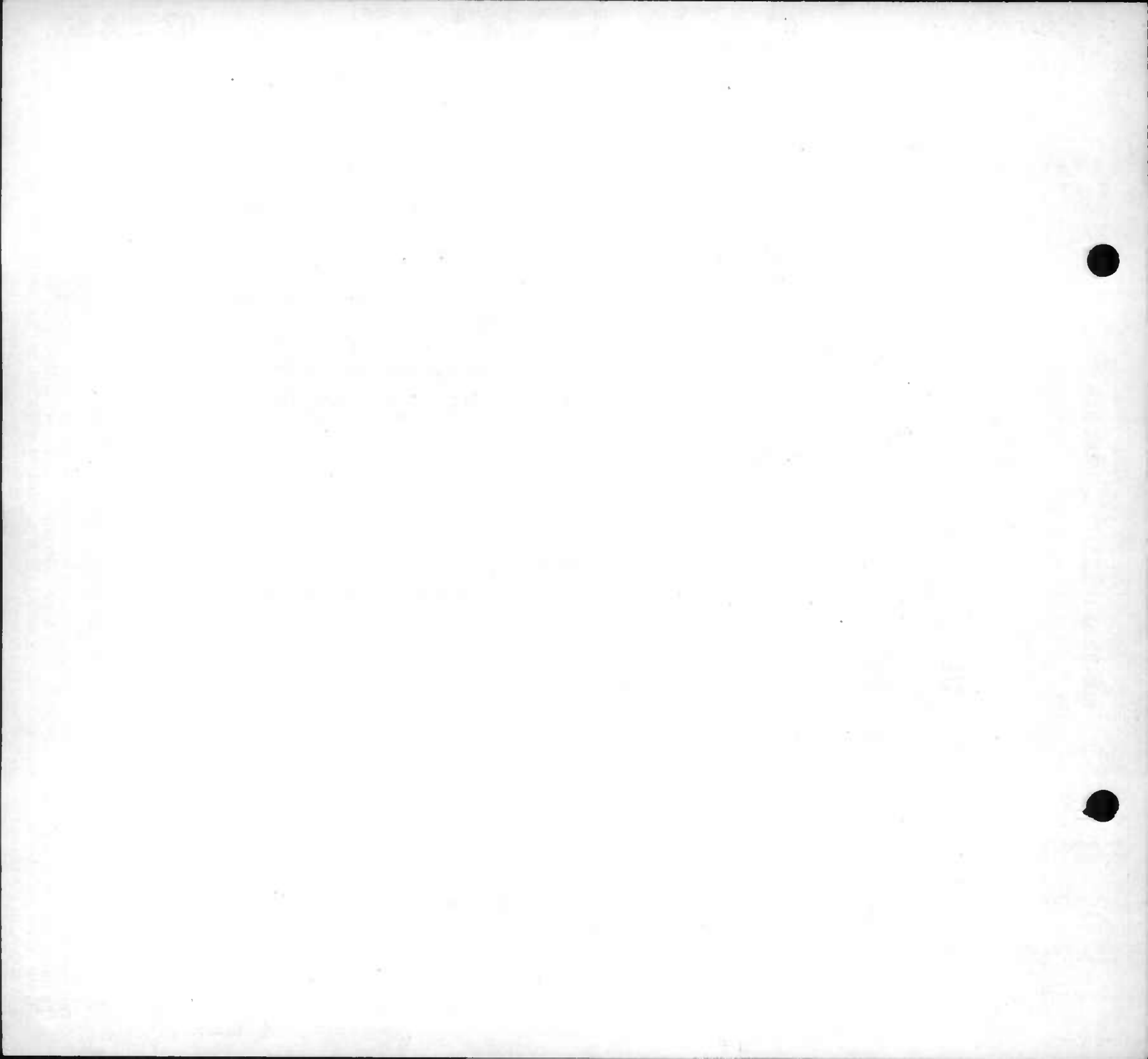




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

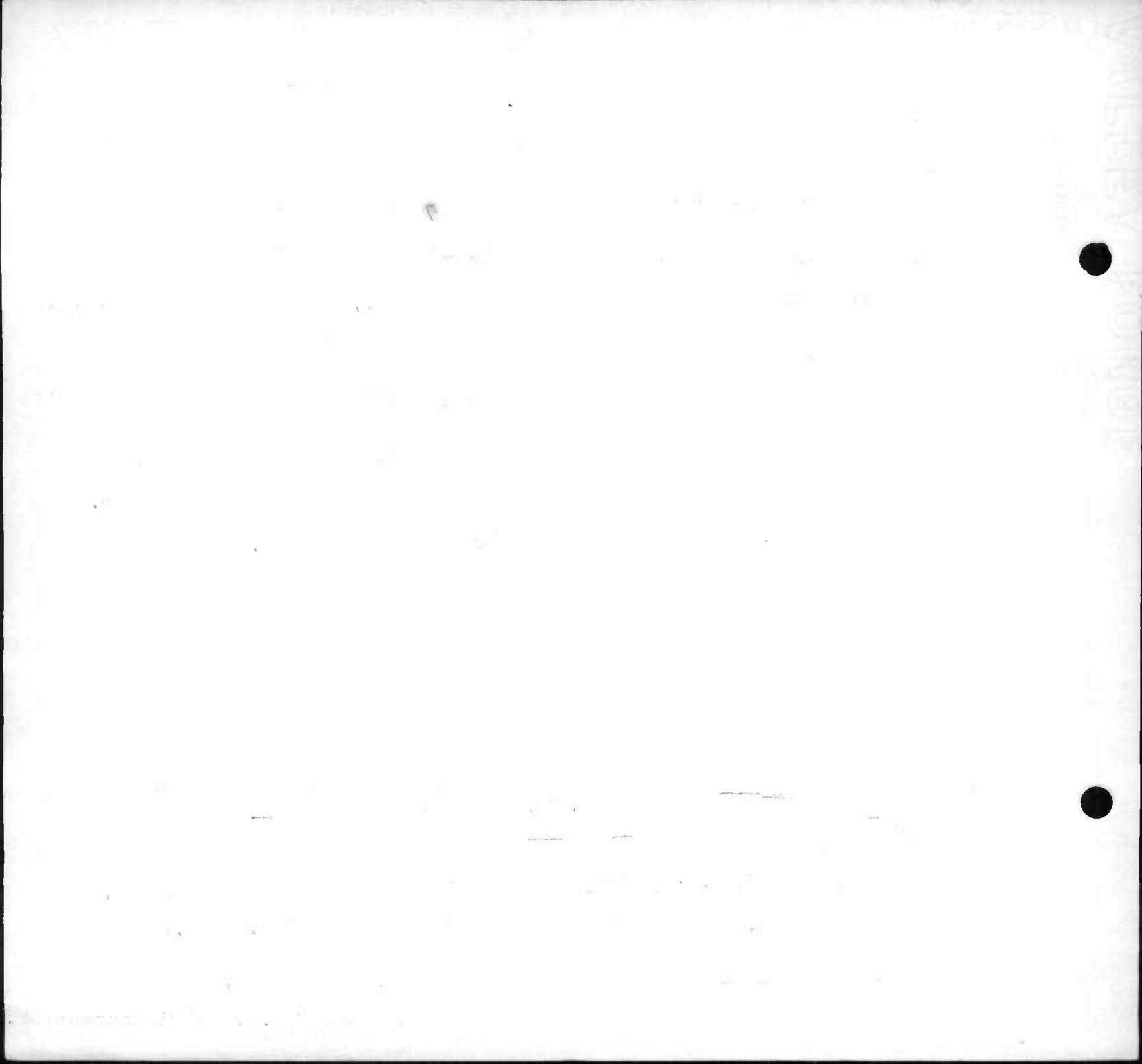
BIRTH NO. <b>67 11226</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>67 11226</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>George E. Thomas</b>			2. DATE AND HOUR OF DEATH <b>November 17, 1967</b> <b>9:30 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>00 3704 Cedardale Road</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-11</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3704 Cedardale Road</b>		
5. SEX <b>Male</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED <b>Widowed</b>	8. DATE OF BIRTH <b>Sept. 13, 1886</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mod carrier</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>George Cozart</b>			14. MOTHER'S MAIDEN NAME <b>Ella ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-03-1937</b>	17. INFORMANT ADDRESS <b>Miss Emily Thomas 420 Manse Court</b>		
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CORONARY OCCLUSION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIOSCLEROTIC-HYPERTENSIVE DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/16/67</b> 19 to <b>11/17/67</b> 19 that (I) (we) last saw the deceased alive on <b>11/16/67</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. H. C. WELCOM</b> M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>W. H. C. WELCOM</b> M.D.				23D. ADDRESS <b>1106 HARLEM AVE 21217</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/21/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Arbutus (Baltimore) Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 22 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Joseph S. Kueh 2222 W. North Ave Baltimore, Md.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 11227</b>	
BIRTH NO. <b>67 11227</b>		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>LAURA HAWKINS</b>		<b>11-20-67</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3607 Windsor Mill Road</b>		A. STATE <b>MARYLAND</b> B. COUNTY	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
		D. STREET ADDRESS (If rural, give location) <b>3607 Windsor Mill Road</b>	
5. SEX <b>F.</b>	6. RACE <b>N.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>3-9-1902</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic Work</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>65</b>
13. FATHER'S NAME <b>JOHN MCCOY</b>		11. BIRTHPLACE (State or foreign country) <b>HORNET CO., NORTH CAROLINA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>ARDELIA WILLIAMS</b>	
17. INFORMANT <b>Mrs. Sallie Carroll</b>		ADDRESS <b>3607 Windsor Mill</b>	
18. <b>331 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>CEREBRO * VASCULAR ACCIDENT</b>		CAUSE OF DEATH <b>HYPERTENSION</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <b>(PREVIOUS STROKE IN JAN. 67)</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) DUE TO	
		(C)	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the undersigned) attended the deceased from <b>Nov. 19, 1967</b> to <b>November 19, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 19, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Joshua R. Mitchell</b>		23B. DATE SIGNED <b>20 NOV. 67</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOSHUA R. MITCHELL III</b>		23D. ADDRESS <b>2202 GARRISON BLVD. BALTO., MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
24C. NAME OF CEMETERY or CREMATORY <b>BALTIMORE NATIONAL CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 22 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Smith</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens St.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11228

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

67 11228

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

GLORIA JORDAN (MACER)

2. DATE AND HOUR OF DEATH

November 21, 1967 6:45 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN (If outside city limits, with RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2730 Lauretta Ave.

5. SEX

Female

6. RACE

Negroid

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

5-12-1928

9. AGE (In years  
last birthday)

39

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Machine Operator

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Samuel Macer

14. MOTHER'S MAIDEN NAME

Elsie Brooks

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

217-20-7289

17. INFORMANT

ADDRESS

Mr. George E. Jordan 2730 Lauretta

18. 1/38, 0 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A) SARCROIDOSIS WITH CHRONIC  
DUE TO PULMONARY FIBROSIS AND(B) OBSTRUCTIVE VENTILATORY  
DUE TO DEFECTS

10 years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

no

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
WorkNot While  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from September 8, 1955 to November 21, 1967,  
that (I) (we) last saw the deceased alive on November 21, 1967 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

David J. Shaw

M.D.

Attending  
Phys.Med.  
DirectorStaff  
Phys.

23B. DATE SIGNED

11/21/67

23C. PHYSICIAN'S  
NAME (Type)

David J. Shaw

23D. ADDRESS

M.D.

Johns Hopkins Hospital

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

11-24-67

24C. NAME of CEMETERY or CREMATORY

BALTIMORE NATIONAL CEM.

24D. LOCATION

(City, town, or county)

BALTIMORE,

MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

NOV 22 1967

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

MORTON &amp; DYETT F.H. 1701 Laurens St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-240		67 11229		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11229	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>SUSANNA K. McCULLOH</b>				11-21 67 6:15 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hospital</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>Maryland</b>		B. COUNTY <b>9-06</b>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>1301 E. 30th St</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>2-14-85</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>American</b>	
13. FATHER'S NAME <b>Andrew Westling</b>				14. MOTHER'S MAIDEN NAME <b>Mary Bullock</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213102434B</b>		17. INFORMANT ADDRESS <b>James H. McCulloh 5102 Denvview Way</b>			
18. <b>443 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Hypertensive</b> <b>cardiovascular disease</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>13</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11-11-67</b> to <b>11-21-67</b> , that (I) (we) last saw the deceased alive on <b>11-18-67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Fred J. Bjornsson</b>				M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Physician <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-21-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>F. BJORNSSON</b>				23D. ADDRESS <b>Maryland General</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-24-67</b>		24C. NAME of CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 22 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>RUCK'S Trophy</b>		ADDRESS	

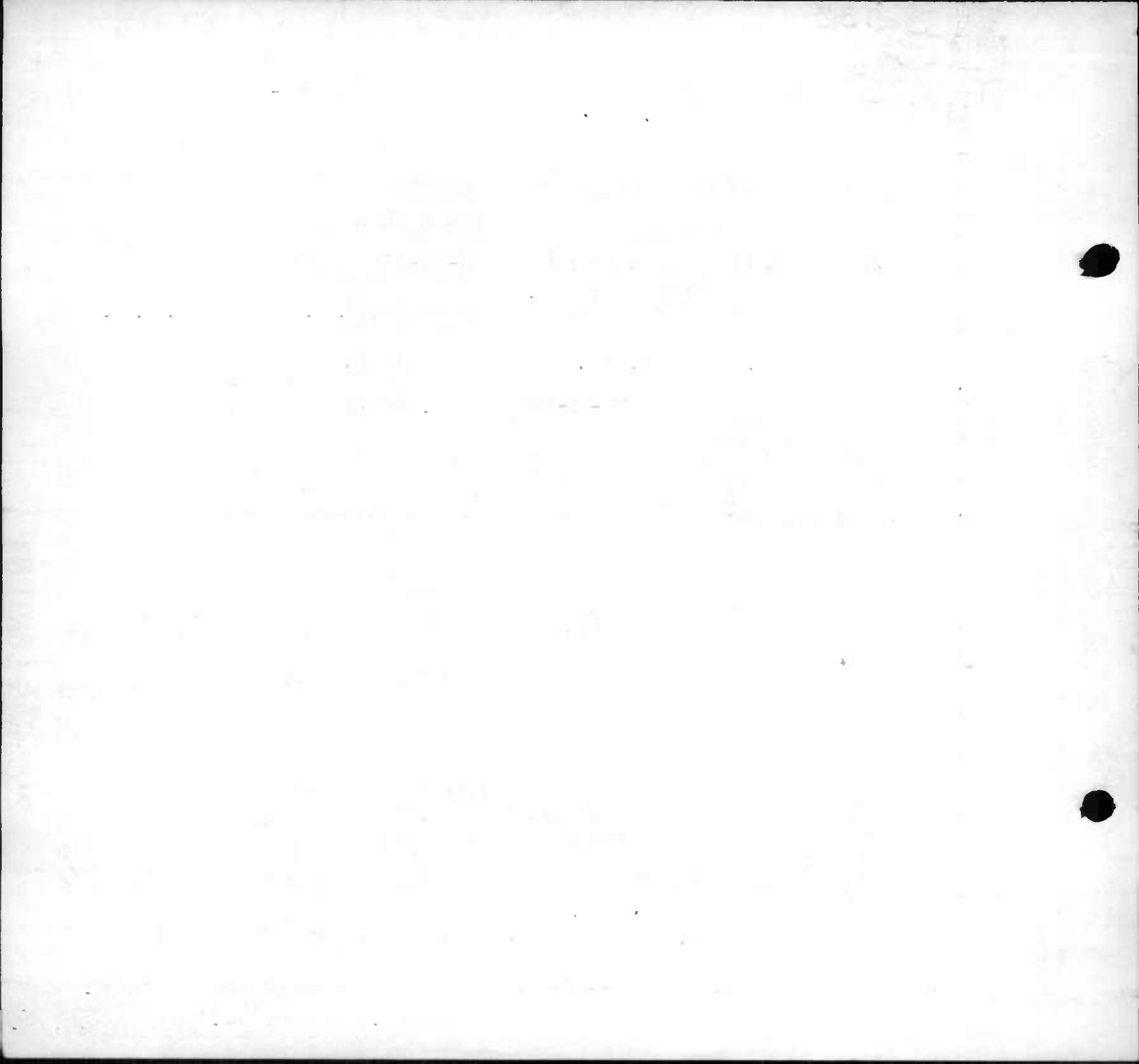




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>3-530</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 11230</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>SCHMIDT, ERNEST E.</b>		2. DATE AND HOUR OF DEATH <b>11/14 - 67 11 05 p.m.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>QUEEN ANN</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Stevensville Md. 67-00</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>		D. STREET ADDRESS (If rural, give location) <b>BOX 56 A</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>4-29-18</b>	9. AGE (In years last birthday) <b>49</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electronic Technician</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Westinghouse Elec. Corporation</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>EDWARD H. SCHMIDT, SR.</b>		14. MOTHER'S MAIDEN NAME <b>BESSIE M. VOGELSON</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-01-3666</b>		17. INFORMANT <b>Mary J. Schmidt</b> ADDRESS <b>Box 56 - A Stevensville, Maryland</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <b>421.14260X</b>		CAUSE OF DEATH <b>Aortic Stenosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Arteriosclerosis &amp; Diabetes</b>			
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>YES</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11/8</b> 19 <b>67</b> to <b>11/14</b> 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>11/14</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.					
23A. SIGNATURE <b>Peter J. Rosen</b>		M.D.	Attending Phys. <input type="checkbox"/>	Med. Director <input type="checkbox"/>	Staff Phys. <input checked="" type="checkbox"/>
23B. DATE SIGNED <b>11/15/67</b>		23C. PHYSICIAN'S NAME (Type) <b>PETER J. ROSEN</b>			
23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Nov 19, 1967</b>	24C. NAME OF CEMETERY or CREMATORY <b>Fort Lincoln Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Prince Georges County Md.</b>	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>		ADDRESS <b>8434 Georgia Ave. Silver Spring, Md.</b>	



50-48-37 D

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-432		67 11231		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11231	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				GERTRUDE SCHULTZ		11/6/67 9:40 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1306 HARFORD AVENUE - #21202			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-20-85	9. AGE (In years last birthday) 82	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) MARYLAND
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY None		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME PASTERFIELD				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-03-5952		17. INFORMANT 21224 RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE MD		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) Adenocarcinoma of stomach with metastases, (B) post-op gastrectomy, (C) obstruction			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/30 to 11/6 1967, that (I) (we) lost saw the deceased alive on 11/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.							
23A. SIGNATURE Paul Michelson				23B. DATE SIGNED 11/6/67		23C. PHYSICIAN'S NAME (Type) DR. PAUL MICHELSON	
23D. ADDRESS BCH-4940 EASTERN AVENUE-BALTIMORE, MD				23E. FUNERAL DIRECTOR Chung O. Wilson			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-17-67		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		24D. LOCATION (City, town, or county) (State) Brooklyn Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 22 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Chung O. Wilson		ADDRESS 1000 Brantley Ave	

10/10/10 10/10/10 10/10/10

10/10/10

W F

Changes of stomach  
with  
get-up  
disturbance

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

L-000

67 11232

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11232

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

FANNIE

LEE

2. DATE AND HOUR PRONOUNCED DEAD

November 20, 1967

6:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

2005 Llewelyn Avenue (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2005 Llewelyn Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

Sept 15 1881

9. AGE (In years  
last birthday)

86

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Louis Stephens

14. MOTHER'S MAIDEN NAME

Victoria Carpenter

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Violet J. Wallace

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic and Hypertensive  
XXXXX Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

11/21/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11-25-67

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem

23D. LOCATION

(City, town, or county)

Baltimore Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 22 1967

24B. NAME OF REGISTRAR

Robert E. Fulkerson

24C. FUNERAL DIRECTOR

Chas. Wilson 1000 Brantley Ave

ADDRESS

100-100000

100-100000

100-100000

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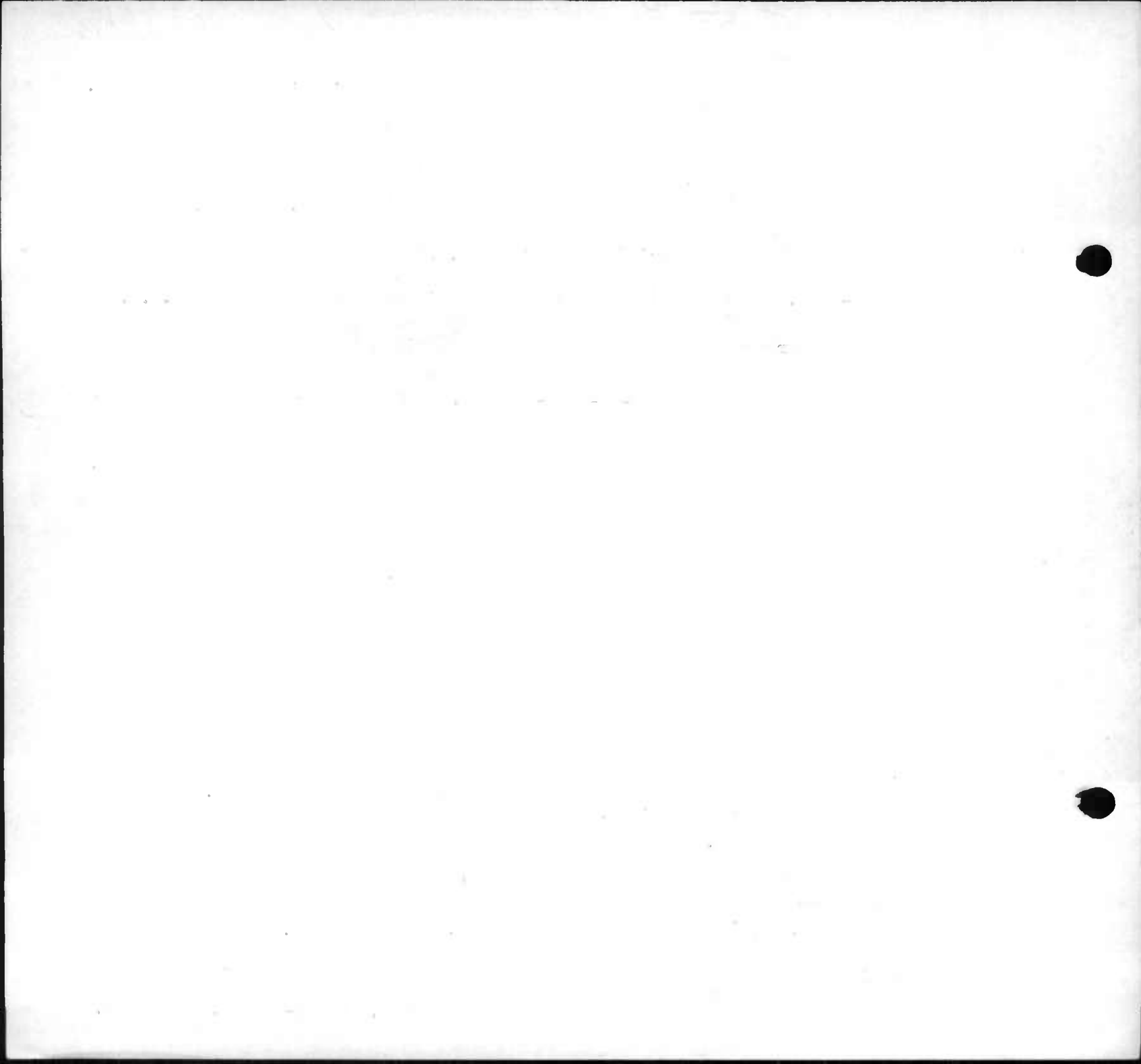
100-100000

100-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>67 11233</b>		CERTIFICATE OF DEATH <b>X</b>		Registered No. <b>67 11233</b>	
1. NAME OF DECEASED (Type or Print) <b>George Washington Tartar</b>			2. DATE AND HOUR OF DEATH <b>Nov. 13, 1967</b>   <b>9: A.</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Johns Hopkins Hospital (DOA)</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore Co</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>7308 Linden Ave. (Overlea)</b>		
5. SEX <b>Male</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify) Married</b>	8. DATE OF BIRTH <b>Aug. 3, 1888</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter - Ret.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore News</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Henry Tartar</b>		
14. MOTHER'S MAIDEN NAME <b>Heddie ? ? ?</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>212-07-5127-A</b>		
16. SOCIAL SECURITY NO. <b>212-07-5127-A</b>			17. INFORMANT ADDRESS <b>Mrs. Mamie Tartar-7308 Linden Avenue (Overlea)</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, pneumonia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac failure</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Secondary anemia</b> DUE TO <b>Multiple myeloma</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>3 months</b> <b>6 months?</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 16, 1966</b> to <b>Nov. 13, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 10, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard R. Rigler</b>				23B. DATE SIGNED <b>11/22/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Richard R. Rigler</b>				23D. ADDRESS <b>1 W. Overlea Ave.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/16/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 22 1967</b>			
25B. NAME OF REGISTRAR <b>Herbert E. Nutter-3035 W. North Ave.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Herbert E. Nutter-3035 W. North Ave.</b>			





1  
V-300

67 11234 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 11234

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HORACE VOID

2. DATE AND HOUR PRONOUNCED DEAD

November 19, 1967 10:56 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2810 W. Franklin St. D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2812 W. Mulberry St.

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Jan. 10, 1952

9. AGE (In years  
last birthday)

15

10. Under 1 Yr. 11 Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

High School

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Willie C. Void

14. MOTHER'S MAIDEN NAME

Christine Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Willie C. Void-2812 W. Franklin Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Gunshot wound of the back  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Gas Station

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2810 W. Franklin St. Peoples G. S.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

11 19 67 10:35

21E. INJURY OCCURRED

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Gun apparently fired accidentally, strik-

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion ing victim  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/24/67

23C. NAME OF CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

NOV 22 1967

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Herbert E. Nutter-3035 W. North Ave.

WALLLEY FORD  
VALLEY FORD

D-416 67 11235		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11235	
M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>MARY DELBRIDGE</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>November 18, 1967 3:45 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1946 Penrose Avenue</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1946 Penrose Avenue</b>	
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>Nov. 10, 1921</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>46</b>
13. FATHER'S NAME <b>Michael Clark</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
17. INFORMANT <b>Joe Washington</b>		ADDRESS	
18. CAUSE OF DEATH <b>416 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Rheumatic Heart Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  II			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> 11/19/67 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>11-24-67</b>	
23C. NAME OF CEMETERY or CREMATORY <b>Intabany Cmt</b>		23D. LOCATION (City, town, or county) (State) <b>Brooklyn NY</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>NOV 22 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
24C. FUNERAL DIRECTOR <b>Sheryl Wilson</b>		24D. ADDRESS <b>1003 B. Cantyle</b>	

46  
Nov. 10, 1921  
North Carolina  
Hunters  
Dr. [illegible]

Robert Clark  
Dr.

Nov. 11 - 27  
Hunters  
Dr. [illegible]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11236		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 11236	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>SCOTT HERBERT JAMES</b>			2. DATE AND HOUR OF DEATH <b>NOV 20 1967 9:30 A M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST AGNES HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY		
5. SEX <b>MALE</b>			6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>
8. DATE OF BIRTH <b>3-1-93</b>			9. AGE (In years last birthday) <b>74</b>		10. If Under 1 Yr. Months: Days 11. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>JAMES SCOTT</b>		
14. MOTHER'S MAIDEN NAME <b>Artidge Bell</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>213 10 8268</b>			17. INFORMANT <b>Artidge Bell</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Insufficiency</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Obstructive Lung Disease</b> <b>Chronic Pulmonary emphysema</b>			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NOX YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>OCT 6 1967</b> to <b>NOV 20 1967</b> and that (I) (we) lost saw the deceased alive on <b>NOV 20 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Alejandro Mejia</b> M.D.				23B. DATE SIGNED <b>11-20-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALEJANDRO MEJIA</b>				23D. ADDRESS M.D. <b>CATON AND WILKENS AVE. BALTIMORE MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/24/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 24 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>			

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ALEXANDER HENRY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11237		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 11237	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>DOYLE WILLIAM ADRIAN/ A.</b>			<b>NOVEMBER 21, 1967 3:30 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVENUE BALTIMORE MARYLAND 21229</b> <i>40</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		
5. SEX <b>MALE</b>			6. RACE <b>WHITE</b>		7. MARRED, NEVER MARRED <b>MARRIED</b>
8. DATE OF BIRTH <b>07/21/96</b>			9. AGE (In years lost birthday) <b>71</b>		10. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		
13. FATHER'S NAME <b>ANTHONY DOYLE</b>			14. MOTHER'S MAIDEN NAME <b>Sallye Cortney</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWII</b>			16. SOCIAL SECURITY NO. <b>218011801</b>		17. INFORMANT ADDRESS <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVE.</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b>			INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>NOVEMBER 20 19 67</b> to <b>NOVEMBER 21 19 67</b> , that (X) (we) last saw the deceased alive on <b>NOVEMBER 21 19 67</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.		23A. SIGNATURE <i>[Signature]</i>		23B. DATE SIGNED <b>11/21/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>E. MARIN</b>		23D. ADDRESS <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVE.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/24/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore</b>		24E. STATE <b>Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 24 1967</b>	
25B. NAME OF REGISTRAR <b>Robert E. Jarboe, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>			

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MEMBER 2 1955

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NAME LAST

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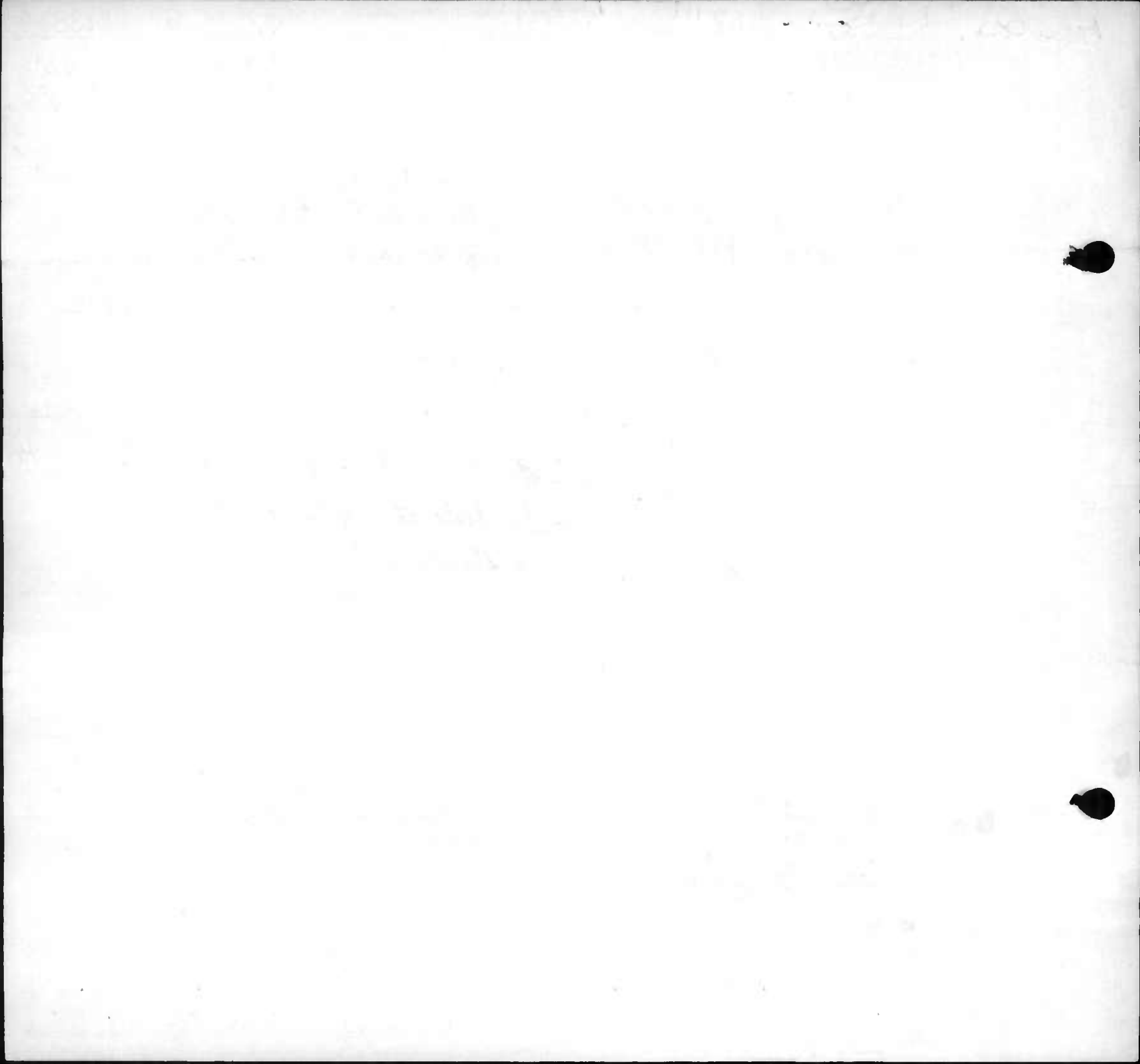
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11238		BALTIMORE CITY HEALTH DEPARTMENT		67 11238	
BIRTH NO.		M.E. CASE NO.		Registered No.	
1. NAME OF DECEASED (Type or Print) <i>Lee Fauth</i>		2. DATE AND HOUR OF DEATH <i>11-18-67</i> <i>1:40</i> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hosp.</i>		A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>New Cut Rd. Box 640</i>			
5. SEX <i>m</i>	6. RACE <i>w</i>	7. MARRIED, NEVER MARRIED <i>WIDOWED, DIVORCED (specify)</i>	8. DATE OF BIRTH <i>8-20-1888</i>	9. AGE (In years lost birthday) <i>79</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>ret</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Farmer own business</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>usa</i>		13. FATHER'S NAME <i>Wm. Fauth</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Welton</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no at unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-14-8556</i>		17. INFORMANT <i>Mr Joseph Fauth</i>	
		ADDRESS <i>633 New Road Kingsville</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>E904.0</i>		CAUSE OF DEATH <i>Spinal Cord Injury associated with</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the underlying condition last.		INTERVAL BETWEEN ONSET AND DEATH <i>24x dislocation of C-63C-7</i> <i>Septicemia</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2-17-67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cervical Monogram</i>		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>garage</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>New Cut Rd Box 640</i>	
21D. TIME OF INJURY (APPROX.) <i>11-1-67</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>found in garage at home</i>	
22. I certify that (I) <del>this</del> <i>hospital</i> attended the deceased from <i>11-1-67</i> to <i>11-18-67</i> , that (I) <del>we</del> last saw the deceased alive on <i>11-18-67</i> and that in (my) <del>our</del> <i>apinian</i> death occurred on the date and hour and from the causes stated above. (I) <del>We</del> <i>did</i> <del>did not</del> view the body after death.					
23A. SIGNATURE <i>J. M. Bonash</i>				23B. DATE SIGNED <i>11/18/67</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-21-1968</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Stephens Cemetery</i>	
24D. LOCATION <i>Baltimore Co. Md.</i>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Fauth</i>	
25C. FUNERAL DIRECTOR <i>Passahan's Funeral Home</i>		ADDRESS			



5-3001

58 28 94 RS

FUNERAL DIRECTOR: IMPORTANT SCOTT DOROTHY 5

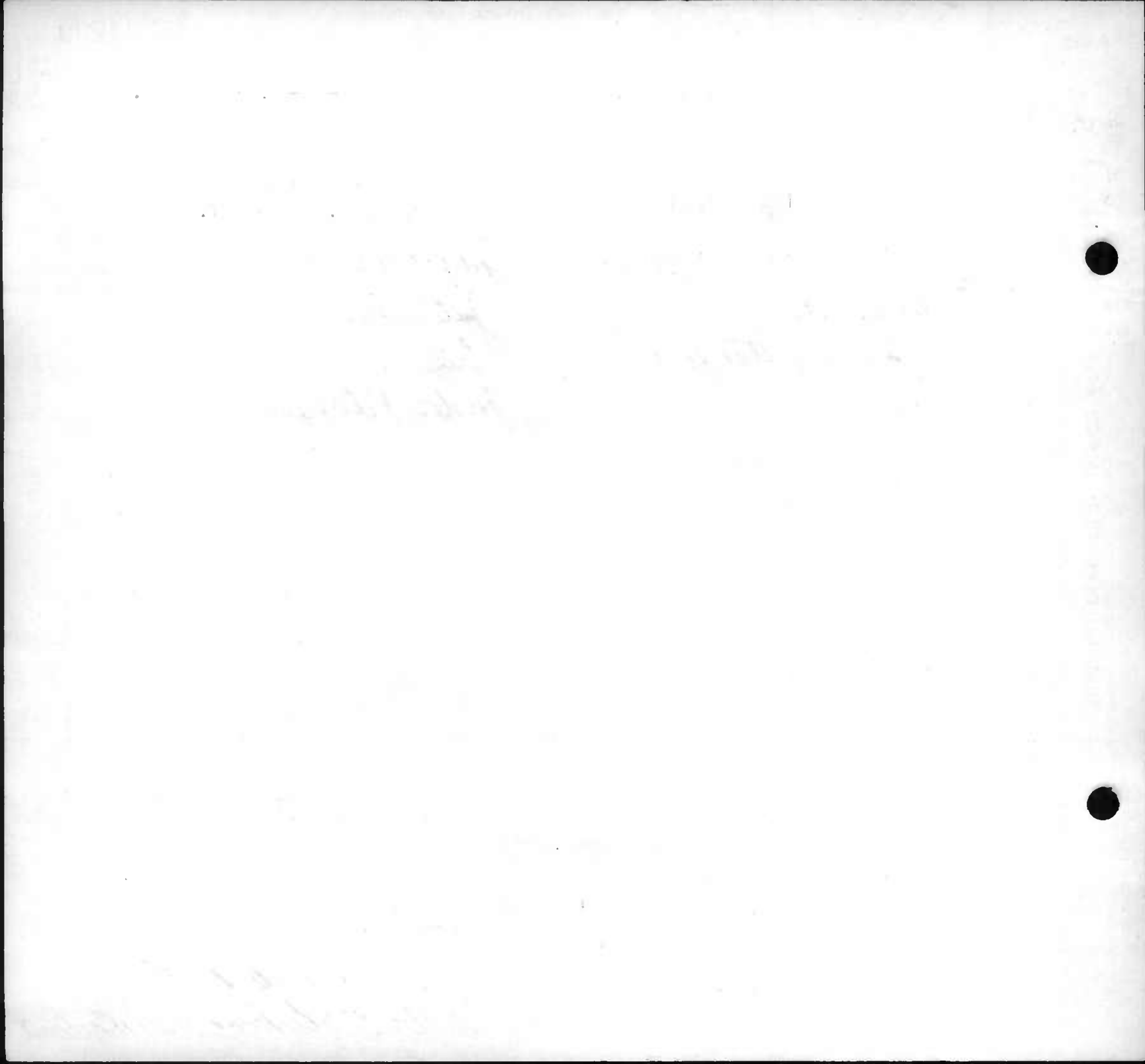
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11239

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 67 11239

BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
DOROTHY SCOTT		11-21-1967 1.45 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
33 JOHNS HOPKINS HOSPITAL		MARYLAND	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
		BALTIMORE, 5	
		D. STREET ADDRESS (If rural, give location)	
		1512 E. EAGER ST.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
FEMALE	NEGRO	Widow	July 17, 1912
9. AGE (In years lost birthday)		10. AGE (In years lost birthday)	
53		53	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Housewife		Jetersville Va.	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
James Pitchford		Cathy ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No			
17. INFORMANT		ADDRESS	
Hester Pitchford			
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		4 days	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		18 months	
ANTECEDENT CAUSES			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
11/8/67	Intestinal obstruction	NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
No			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (H) (this hospital) attended the deceased from 11/8 1967 to 11/21 1967, that (H) (we) lost saw the deceased alive on 11/20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
[Signature]		11/21/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
DENIS H. TYRAS		JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Nov 25/67	My Auburn Cem.	Essexport Md.
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR
NOV 24 1967		Robert E. Fairbank	William E. Ellickson 1129 E. Calhoun



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-400		67 11240		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11240	
<b>CERTIFICATE OF DEATH</b>							
1. NAME OF DECEASED (Type or Print) <b>Powell, Ellsworth H.</b>				2. DATE AND HOUR OF DEATH <b>11/20/67 11:30 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 The Johns Hopkins Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, give RURAL and give township) <b>Baltimore 8-05</b> D. STREET ADDRESS (If rural, give location) <b>1700 E. 25th Street</b>			
5. SEX <b>Male</b>	6. RACE <b>Negroid</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>1-9-00</b>	9. AGE (In years last birthday) <b>68-65</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>md.</b>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Thomas Powell</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Reynolds</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Henry Powell</b>		ADDRESS <b>1700 E 25th St</b>	
18. <b>493X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Klebsiella Pneumoniae</b> (A) DUE TO  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>ASCENDING CHF</b>  19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11/12</b> 19 <b>67</b> to <b>11/20</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11/20</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Henry R. Black</b> M.D.				23B. DATE SIGNED <b>11/20/67</b>		23C. PHYSICIAN'S NAME (Type) <b>HENRY R. BLACK</b> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/25/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Westport Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 24 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, MA</b>		25C. FUNERAL DIRECTOR <b>Milton E. Erickson</b>		ADDRESS <b>11297 Carline St</b>	

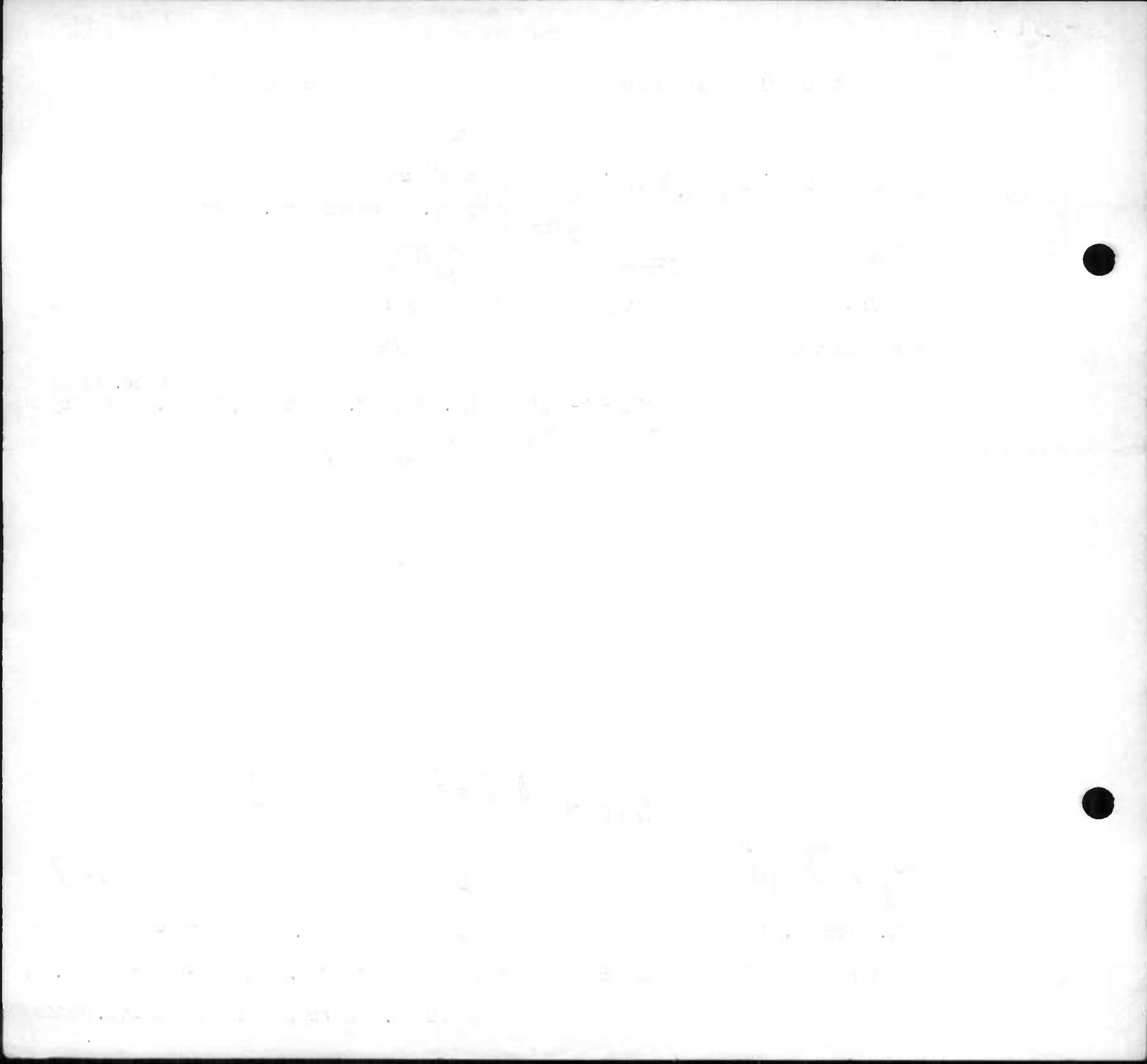
100-111111  
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100-111111

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

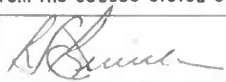
BIRTH NO. 67 11241		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11241	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) George Theodore Otterbein		2. DATE AND HOUR OF DEATH November 21, 1967 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION 00 238 S. Monastery Ave. Baltimore, Md. 21229		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 20-08 D. STREET ADDRESS (If rural, give location) 238 S. Monastery Ave. 21229			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/21/78	9. AGE (In years last birthday) 89	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Adam Otterbein		14. MOTHER'S MAIDEN NAME Marie Simon	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-03-5852		17. INFORMANT Mrs. Marie G. Otterbein, 238 S. Monastery Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.0 I arteriosclerotic heart disease		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-7-60 to 11-21-67, that (I) (we) last saw the deceased alive on 11-17-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Harry S. Gimbel		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE, SIGNED 11-22-67	
23C. PHYSICIAN'S NAME (Type) Dr. Harry S. Gimbel		23D. ADDRESS M.D. 4605 Edmondson Ave. WI 7-2663			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/24/67		24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery	
24D. LOCATION 6020 Gov. Ritchie Highway		Md.			
25A. DATE REC'D BY HEALTH DEPT. NOV 24 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11242</b>	
BIRTH NO. <b>67 11242</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>TINLEY, DAISY G</b>		2. DATE AND HOUR OF DEATH <b>NOVEMBER 23, 1967 4:30 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST AGNES HOSPITAL CATON &amp; WILKENS AVENUES BALTIMORE, MARYLAND 21229</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 21229 25-31</b>			
		D. STREET ADDRESS (If rural, give location) <b>589 BEECHFIELD AVENUE</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b>	8. DATE OF BIRTH <b>08/01/88</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>WILLIAM DOWNEY</b>		14. MOTHER'S MAIDEN NAME <b>AGNES BUCKINGHAM</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-22-1426</b>		17. INFORMANT ADDRESS <b>ST AGNES HOSPITAL'S RECORDS</b>	
18. <b>331X I</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b>		(A) <b>CEREBRO VASCULAR ACCIDENT</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>6-8 hours</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>ESSENTIAL HYPERTENSION</b> DUE TO			
		(C)			
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>NOVEMBER 22 1967</b> to <b>NOVEMBER 23 1967</b> , that (X) (we) last saw the deceased alive on <b>NOVEMBER 23 1967</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11/23/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>RODOLFO M. REVILLA</b>		23D. ADDRESS <b>ST AGNES HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-27-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Pikesville, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 24 1967</b>		25B. NAME OF REGISTRAR <b>R. E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>	

NOV 23 1967 11:30 A.M.

ST. AGNES HOSPITAL  
Baltimore, Maryland 21205  
Cotton & Wilkins Avenue  
ST. AGNES HOSPITAL  
Baltimore, Maryland 21205  
DRUGS - WIDOWED

HOUSEWIFE  
WILLIAM BOWEN  
ST. AGNES HOSPITAL  
Baltimore, Maryland 21205

NOV 23 1967 11:30 A.M. XX  
NOV 23 1967 11:30 A.M. XXXX  
NOV 23 1967 11:30 A.M. X

ST. AGNES HOSPITAL  
RODOLFO M. REVILLA

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 11243</u>
BIRTH NO. <u>67 11243</u>		CERTIFICATE OF DEATH		
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <u>11-19-67 2:22 P.M.</u>		
1. NAME OF DECEASED (Type or Print) <u>LAURA VIRGINIA FRANKLIN</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hosp.</u>		A. STATE <u>md.</u> B. COUNTY <u>Bells Co.</u>		
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Ba/to.</u>		
		D. STREET ADDRESS (If rural, give location) <u>3102 Puffy Hill Rd. Ave.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widow</u>	8. DATE OF BIRTH <u>9-25-01</u>	9. AGE (In years last birthday) <u>66</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>md.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>GEORGE L. CLATICE</u>		14. MOTHER'S MAIDEN NAME <u>SADIE MYRAPH</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>?</u>	17. INFORMANT <u>ALBERT H. CLAUDICE</u>	
				ADDRESS <u>6108 Glen Oak Ave.</u>
18. <u>561.5 I</u>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <u>pulmonary embolus</u>		
ANTECEDENT CAUSES		(B) _____		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <u>11-16-67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>INCARCERATED hernia</u>		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>11-16</u> 19 <u>67</u> to <u>11-19</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-19</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Frank Palmisano M.D.</u>				23B. DATE SIGNED <u>11-19-67</u>
23C. PHYSICIAN'S NAME (Type) <u>FRANK PALMISANO</u>		23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/22/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Moreland Memorial Park</u>
				24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 24 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>Robert C. Altenburg Funeral Home, Inc.</u>
				ADDRESS <u>6009 Harford Rd.</u>

Division Memorial 1928 2102 0444 Hill St. 1921 15

7 12 10-26-94 22

11-12-67 unclassified 10-21-71

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

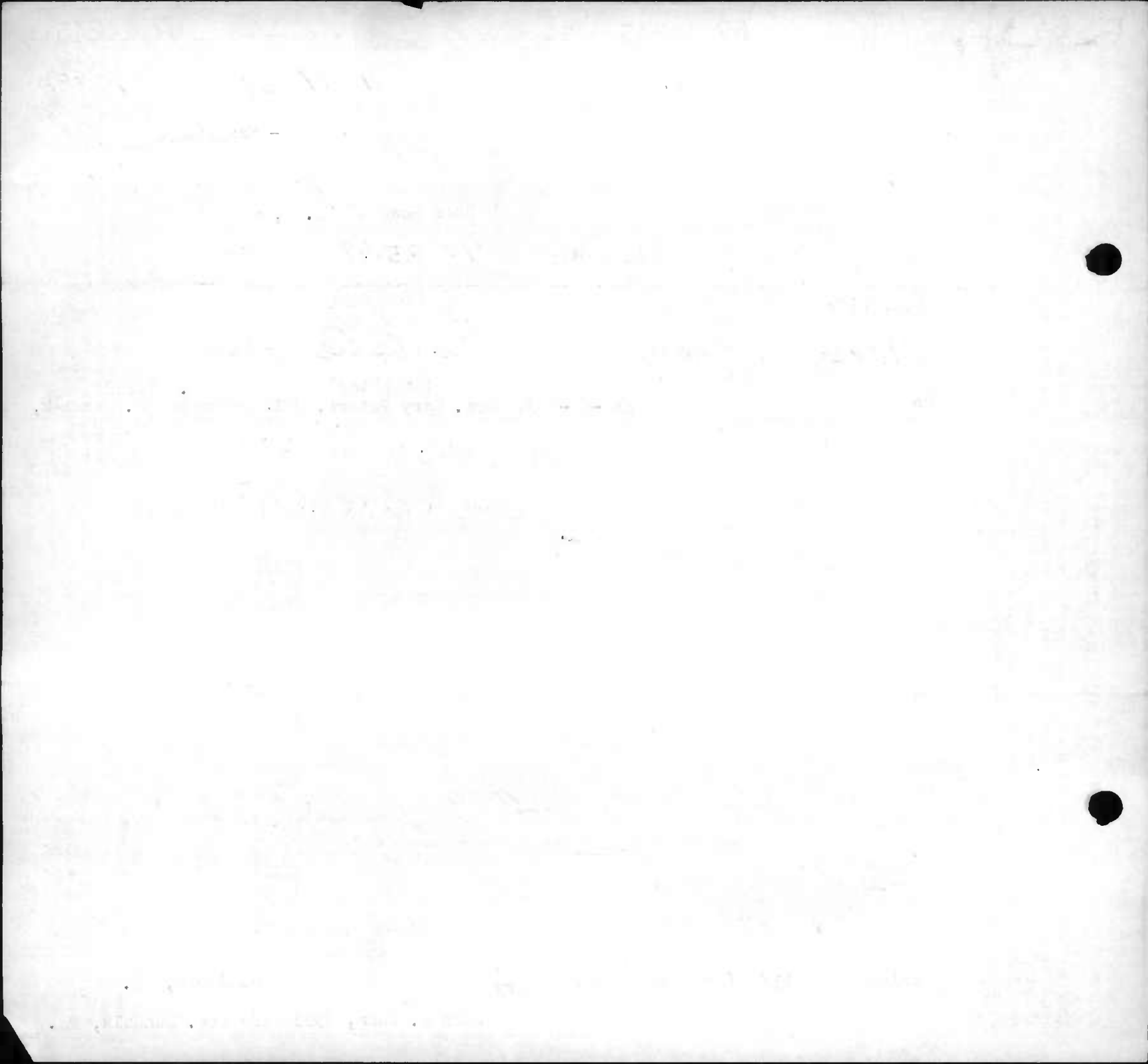
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 11244	
BIRTH NO. 67 11244		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Margaret Jane Gowland		2. DATE AND HOUR OF DEATH Nov. 21, 1967 6 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY Maryland			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 1631 N. Calvert St.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		12-05	
		D. STREET ADDRESS (If rural, give location) 1631 N. Calvert St.			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH July 2, 1892	9. AGE (In years last birthday) 75	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) York, England	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Boynton		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Wm. H. Gowland 4413 Harcourt Rd. #21214	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.) 420.11-260X Coronary Thrombosis Instant arteriosclerotic heart disease 1958 Hypertension 1958		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus 1958					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-2-1958 to 11-21-1967, that (I) last saw the deceased alive on 11-13-1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert Siver		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11-22-67	
23C. PHYSICIAN'S NAME (Type) Dr. Robert Siver		M.D. 23D. ADDRESS 3105 N. Charles St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/24/67		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. NOV 24 1967		25B. NAME OF REGISTRAR Robert E. Siver		25C. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home 6500 York Road Balto., Md. 21212	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
67 11245 CERTIFICATE OF DEATH						Registered No. 67 11245					
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>(Mary) May Barnett</b>											
2. DATE AND HOUR OF DEATH <b>11-21-67 1040 A.M.</b>											
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>48 Maryland General Hospital</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore Co.</b> C. CITY OR TOWN (If outside city limits write RURAL and give township) <b>Fort Howard</b> D. STREET ADDRESS (If rural, give location) <b>Ross Road &amp; Ave. B.</b>					
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>10-25-97</b>		9. AGE (In years last birthday) <b>70</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>				12. CITIZEN OF WHAT COUNTRY? <b>American</b>	
13. FATHER'S NAME <b>Theodore T. Beery</b>						14. MOTHER'S MAIDEN NAME <b>Isabelle Paul</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>216-54-0694</b>		17. INFORMANT (Daughter) <b>Mrs. Mary Peters, 7610 Parkwood Rd. Dundalk, Md. 21222</b>				ADDRESS	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH <b>MYOCARDIAL INFARCT</b> (A) DUE TO <b>ARTEROSCLEROTIC HEART DISEASE</b> (B) DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH <b>1-2 wks</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11-10-1967</b> to <b>11-21-1967</b> , that (I) (we) last saw the deceased alive on <b>11-21-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Fred Bjornsson</b>								M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-21-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>F BJORNSSON</b>								23D. ADDRESS <b>Maryland General Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>11/24/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 24 1967</b>				25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>				25C. FUNERAL DIRECTOR ADDRESS <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

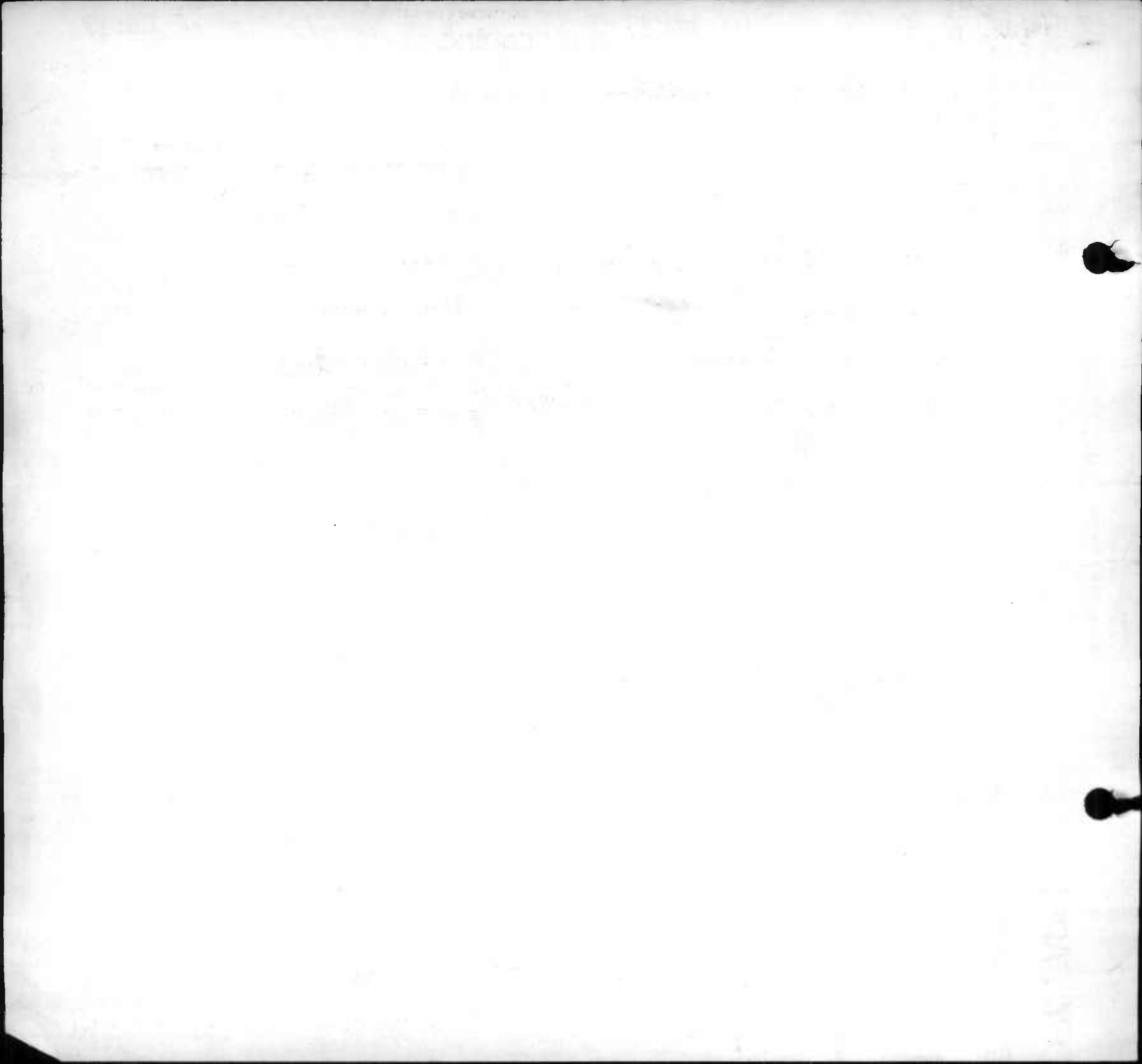
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 11246		<b>CERTIFICATE OF DEATH</b>		67 11246	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>BAILEY, Guy Franklin</b>			<b>18 Nov 1967 10:30 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>University of Maryland Hospital</b>			A. STATE <b>Maryland</b> B. COUNTY <b>Washington</b>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Hagerstown 71-03</b>		
			D. STREET ADDRESS (If rural, give location) <b>17 Haywood Circle</b>		
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED, NEVER MARRIED WIDOWED <b>Married</b>	8. DATE OF BIRTH <b>2 March 1924</b>	9. AGE (In years last birthday) <b>43</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Reproduction worker</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Robert A. Bailey</b>			14. MOTHER'S MAIDEN NAME <b>Rose Wolfe</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W. W. Two</b>		16. SOCIAL SECURITY NO. <b>219-14-9637</b>	17. INFORMANT <b>Florence Bailey</b>		ADDRESS <b>same</b>
18. <b>411X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Embolism</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Rheumatic Valvular Disease</b> <b>Aortic Valve replaced with Starr-Edward prosthesis</b>			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12 Nov 1967</b> to <b>18 Nov 1967</b> , that (I) (we) last saw the deceased alive on <b>18 Nov 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Santos, C.M.D.</b>				23B. DATE SIGNED <b>18 Nov 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jeff S. Santos</b>				23D. ADDRESS <b>University of Maryland Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-21-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Rose Hill Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Clearspring, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 24 1967</b>			
25B. NAME OF REGISTRAR <b>John H. Bast, Jr.</b>		25C. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro Maryland</b>			

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side. The text is mirrored and difficult to decipher.]*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

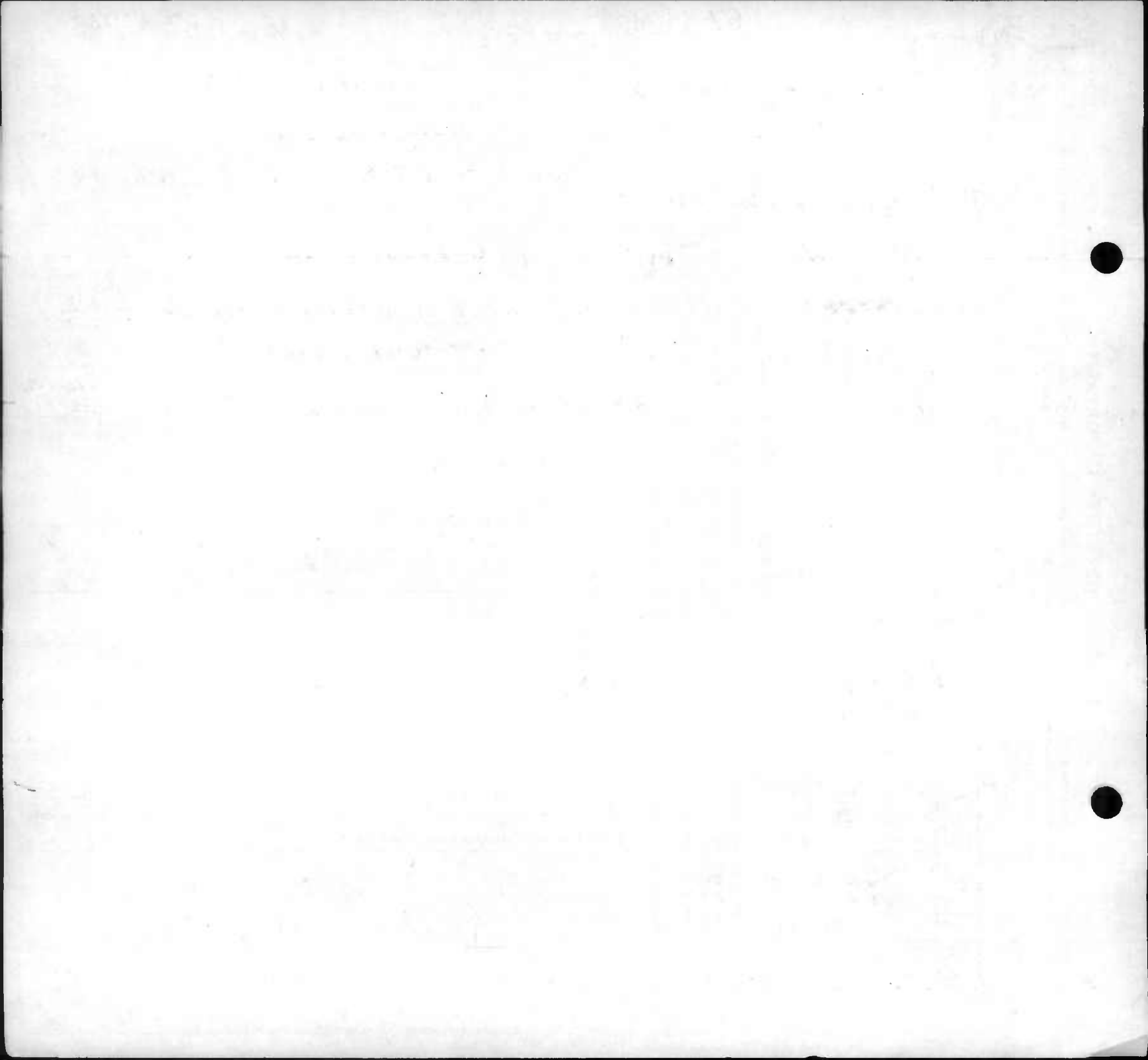
67 11247		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11247	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>OLIVER BYRENSMAN TRAVERS</b>				11/19/67 3:50 EST. A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY OF MARYLAND HOSP.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>2256 LINDEN AVE</b>			
5. SEX <b>M</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>DIVORCED</b>	8. DATE OF BIRTH <b>8/15/15</b>	9. AGE (In years last birthday) <b>52</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>OLIVER TRAVERS</b>		14. MOTHER'S MAIDEN NAME <b>LILLIAN QUEEN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WW II</b>		16. SOCIAL SECURITY NO. <b>157-01-0965</b>		17. INFORMANT <b>ZELDA T. THOMAS 19-B Lafayette Ave</b>	
18. <b>79301</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(A) <b>BRAIN STEM COMPRESSION</b> DUE TO (B) <b>GLIOBLASTOMA. MULTIFORME</b> DUE TO <b>RIGHT FRONTAL LOBE</b> (C) <b>6 MOS.</b>			
19A. DATE OF OPERATION <b>7 JULY 1967</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>@ FRONTAL GLIOMA.</b>		20A. AUTOPSY? (Yes or No) <b>NO.</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/11/1967</b> to <b>11/19/1967</b> , that (I) (we) lost saw the deceased alive on <b>11/11/1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ronald L. Paul</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11/19/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>RONALD L. PAUL</b>		23D. ADDRESS <b>UNIV. OF MARYLAND HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11-22-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTIMORE NATIONAL</b>	
24D. LOCATION <b>BALTIMORE</b>		(City, town, or county) (State) <b>Ind.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 24 1967</b>		25B. NAME OF REGISTRAR <b>R. E. FARRER</b>		25C. FUNERAL DIRECTOR <b>C. E. HICKS III</b>	
				ADDRESS <b>ANNAPOLIS, MD</b>	



# FUNERAL DIRECTOR: IMPORTANT

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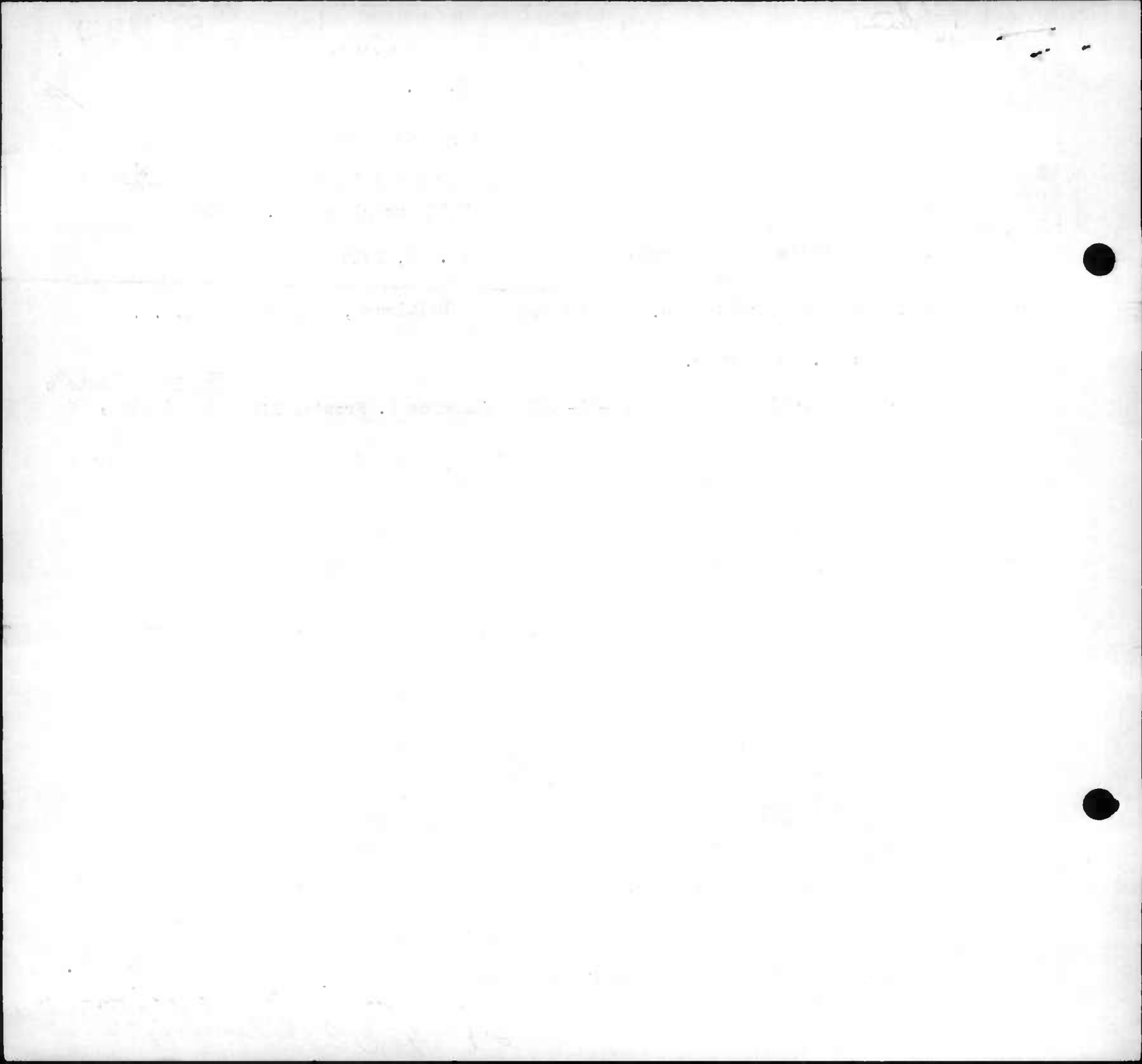
BIRTH NO. 67 11248		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11248	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type at Print) SMITH, HARRY D.		2. DATE AND HOUR OF DEATH 11-18-67, 6:30 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND-21163 B. COUNTY Howard Co.			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Md. 730 Ashburton Street		C. CITY OR TOWN (If outside city limits, write RURAL and give township) WOODSTOCK 63-00			
D. STREET ADDRESS (If rural, give location) WOODSTOCK ROAD					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 6-6-95	9. AGE (In years last birthday) 82	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10B. KIND OF BUSINESS OR INDUSTRY HARDWOOD FLOOR		11. BIRTHPLACE (State or foreign country) RANDALLSTOWN MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME (Unknown) SMITH		14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-32-3861		17. INFORMANT Mrs S. Elizabeth Smith	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PERITONITIS; RUPTURED SIGMOIDAL MASS		19. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 11-14-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ACUTE ABDOMEN		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-13-1967 to 11-18-1967, that (I) (we) last saw the deceased alive on 11-18-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thankam B. Pillai		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11-18-67	
23C. PHYSICIAN'S NAME (Type) DR. THANKAM B. PILLAI		23D. ADDRESS Lutheran Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/21/67		24C. NAME OF CEMETERY or CREMATORY Woodlawn	
24D. LOCATION Woodlawn		24E. (City, town, or county) (State) Md			
25A. DATE RECD BY HEALTH DEPT. NOV 24 1967		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Loring Byers	
25D. ADDRESS 8728 Liberty Rd.					



# FUNERAL DIRECTOR: IMPORTANT

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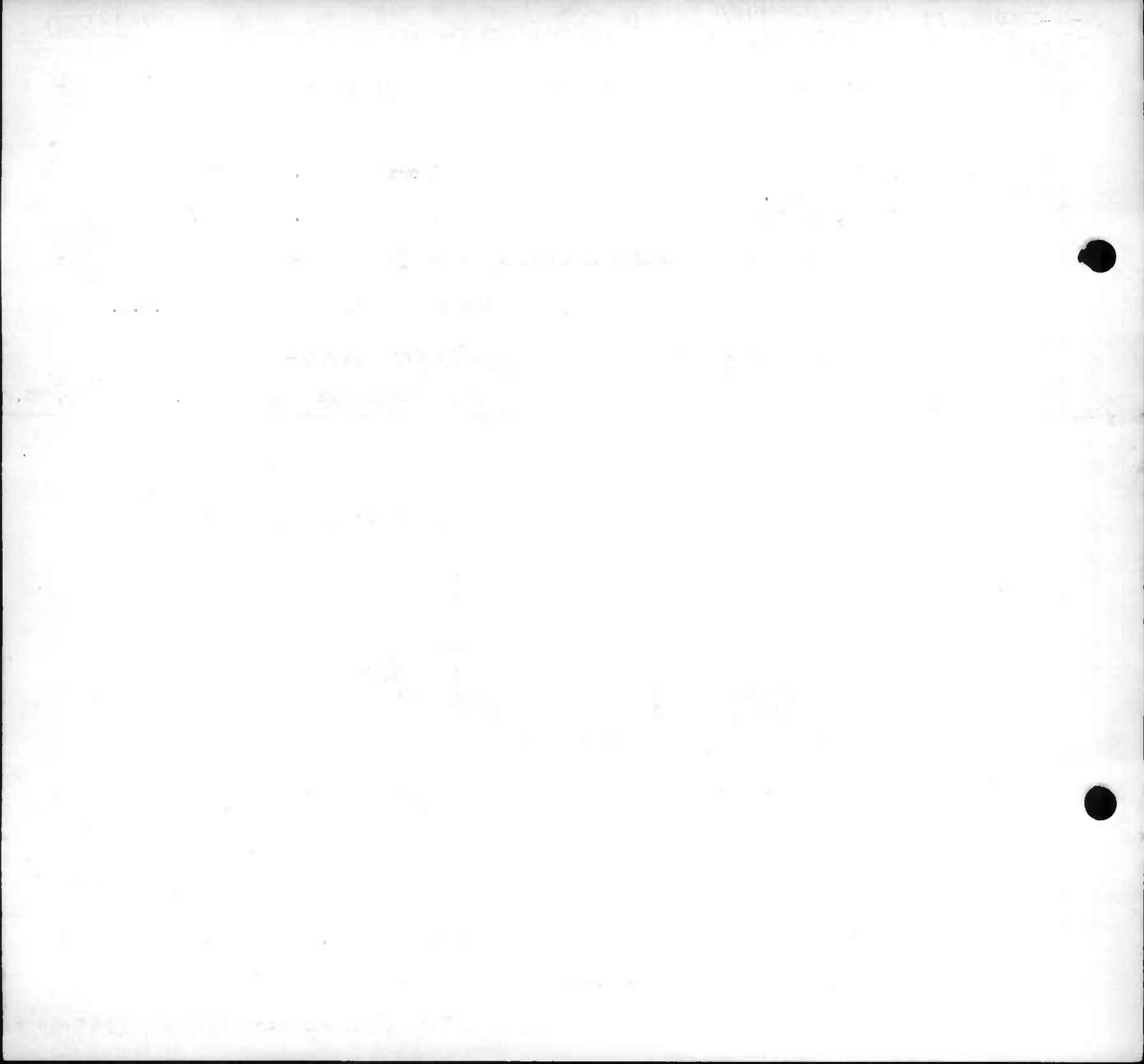
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11249</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>F-626</b></span> <span><b>67 11249</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO. <b>67 11249</b>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>Frazier Clarence L. Jr.</b>			2. DATE AND HOUR OF DEATH <b>11/20/67 110<sup>00</sup> A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hosp of Baltimore</b> <b>42</b>			A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore Co</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>rural Baltimore 53-00</b> D. STREET ADDRESS (If rural, give location) <b>7412 Rockridge Road 21208</b>		
5. SEX <b>Male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED <b>Married</b>	8. DATE OF BIRTH <b>Feb. 20, 1916</b>	9. AGE (In years last birthday) <b>51</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pres. Vern Lee Finishing Co. Bookbinding</b>			11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Clarence L. Frazier Sr.</b>			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes wwl</b>			16. SOCIAL SECURITY NO. <b>218-03-9217</b>		17. INFORMANT <b>Clarence L. Frazier 111</b>
			Box <b>147</b> B Route <b>6</b>		Westminster, Md
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/19</b> 19 <b>67</b> to <b>11/20</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11/20</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Kennet Wether</b>				23B. DATE SIGNED <b>11/20/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>KENNET WETHER</b>				23D. ADDRESS <b>Kenai Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/22/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Meadowridge Memorial</b>	
24D. LOCATION <b>Wash. Blve &amp; Dorsey rd.</b>		24E. LOCATION (City, town, or county) (State) <b>Howard Co Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 24 1967</b>		25B. NAME OF REGISTRAR <b>Philip E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Randall B. Smith</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>H-632</u> <u>67 11250</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67 11250</u>	
M.E. CASE NO. <u>34-06-14</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>HARDESTY MARGARET</u>		2. DATE AND HOUR OF DEATH <u>11-20-67</u> <u>7:29</u> P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Maryland # 21224</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>26-12</u> D. STREET ADDRESS (If rural, give location) <u>4940 Eastern Ave. # 21224</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married WIDOWED</u>	8. DATE OF BIRTH <u>9-21-1886</u>	9. AGE (in years last birthday) <u>81</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>SYLVESTER JETT</u>		14. MOTHER'S MAIDEN NAME <u>JULIA GRAY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>BCH: Records 4940 Eastern Ave. Baltimore, Md.</u> ADDRESS #21224	
18. <u>453X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Probable Sepsis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Gangrenous @ gut toe</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>7-27</u> 19 <u>64</u> to <u>11-20</u> 19 <u>67</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>11-20</u> 19 <u>67</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>P. Desmond</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11-20-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>P. Desmond</u>		23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave. Baltimore, Maryland #21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11/24/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>GARDENS OF FAITH</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 24 1967</u>		25B. NAME OF REGISTRAR <u>P. E. Jackson</u>		25C. FUNERAL DIRECTOR <u>J. E. CONNELLY SONS</u>	
25D. ADDRESS <u>300 MA...</u>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11251		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11251	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Vincent Tondi</i>		2. DATE AND HOUR OF DEATH <i>11-22-67 2:00 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>36 Franklin Square Hospital</i>		A. STATE <i>Maryland</i> B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 19-03</i>			
		D. STREET ADDRESS (If rural, give location) <i>295. Calhoun St. (21223)</i>			
5. SEX <i>Male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>4/15/1882</i>	9. AGE (In years last birthday) <i>85</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Tailor</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Clothing Co</i>		11. BIRTHPLACE (State or foreign country) <i>Italy</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>Annunziata Tondi</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>212-01-8399</i>		17. INFORMANT <i>Chart Record</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>C. V. A.</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>None</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>11-19-1967</i> to <i>11-22-1967</i> , that (I) <i>we</i> last saw the deceased alive on <i>11-22-1967</i> and that in (my) <i>our</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>we</i> (did) (did not) view the body after death.			
23A. SIGNATURE <i>J. Lee</i>		M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>11-22/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>J. Lee</i>		23D. ADDRESS <i>FRANKLIN SQUARE HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/25/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Lorraine Park Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Woodlawn Balto. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 24 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>	
25C. FUNERAL DIRECTOR <i>John J. Cowan &amp; Son Inc.</i>		ADDRESS <i>401 Hollins St.</i>			

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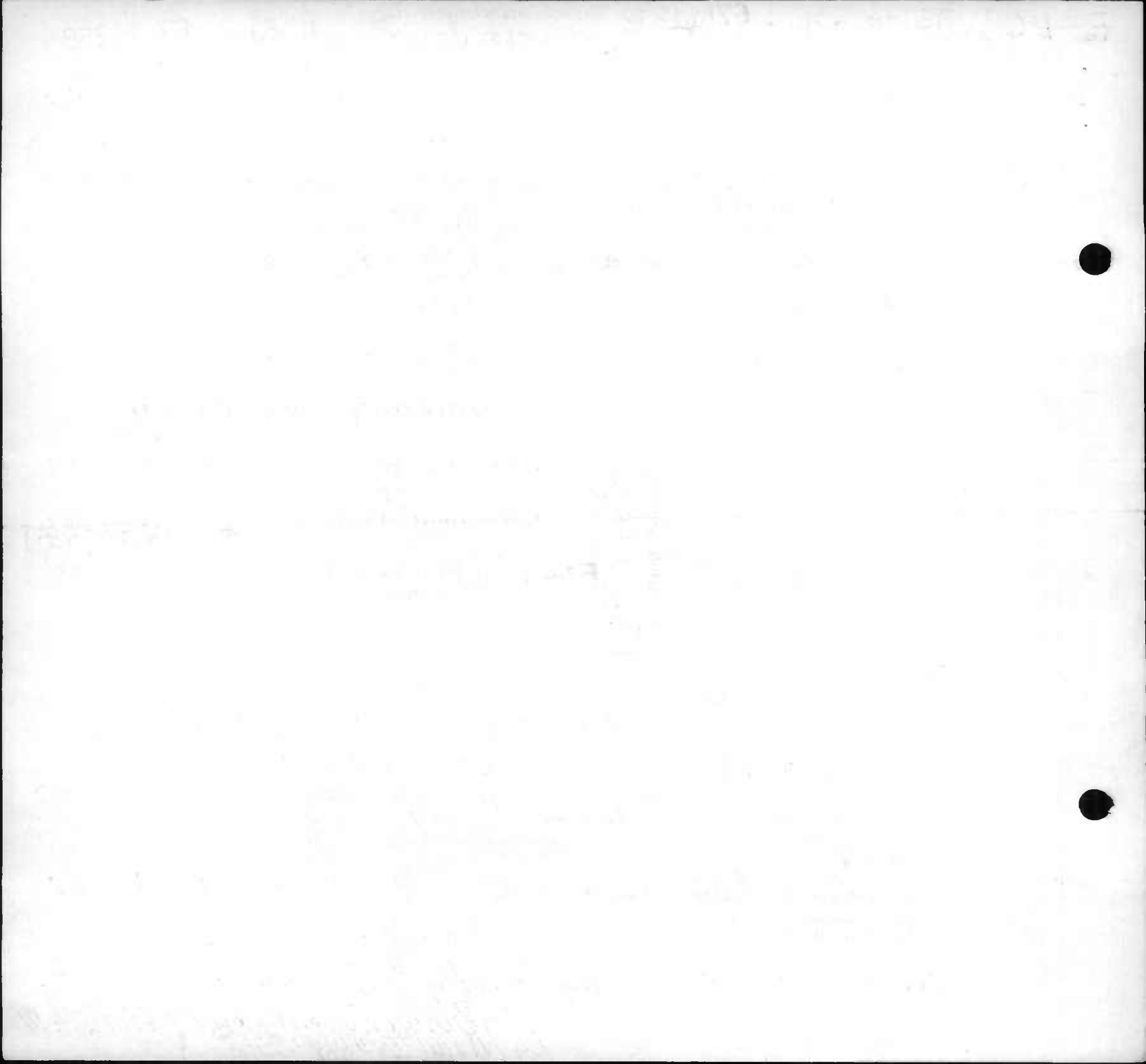
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

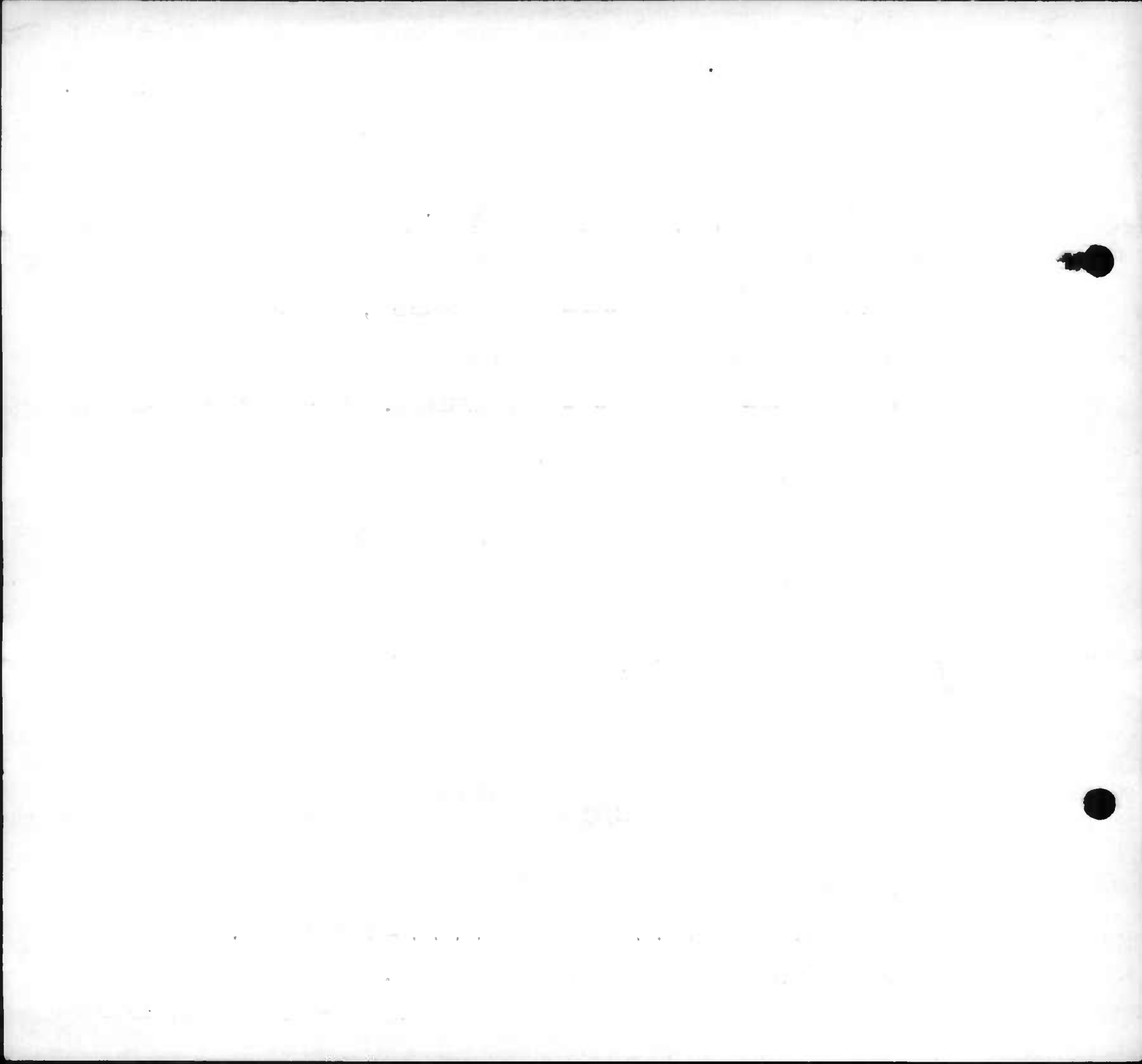
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>67 11252</u>	
<b>1. NAME OF DECEASED</b> (Type or Print) <u>Evelyn M. Fuller</u>				<b>2. DATE AND HOUR OF DEATH</b> <u>8:20 AM 21 NOV '67</u>   <u>8:20 AM</u>			
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>38 University Hospital</u> <u>Baltimore, Md.</u>				<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Allegheny Co.</u> <b>5. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <u>Cumberland, Md.</u> <b>6. STREET ADDRESS</b> (If rural, give location) <u>Bx 158</u>			
<b>5. SEX</b> <u>F</u>	<b>6. RACE</b> <u>W</u>	<b>7. MARRIED, NEVER MARRIED</b> WIDOWED, DIVORCED (specify) <u>MARRIED</u>		<b>8. DATE OF BIRTH</b> <u>9-2-07</u>	<b>9. AGE</b> (In years last birthday) <u>60</u>	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>Md.</u>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Ezra Bobo</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Stella M. Hartman</u>				<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>none</u>				<b>17. INFORMANT</b> ADDRESS <u>University Hosp Records</u>			
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease or complication which caused death.) <u>Cardiovascular Collapse</u>				<b>19. CAUSE OF DEATH</b> (A) DUE TO <u>Cardiovascular Collapse</u> (B) DUE TO <u>Cerebral Ischemia</u> <u>Secondary to Surgery (I.M. Surgery)</u> <u>For Valve Failure due to Rheumatic Heart Disease</u> <u>(6 days)</u>			
<b>20. ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. <u>None (except surg)</u>				<b>21. INTERVAL BETWEEN ONSET AND DEATH</b> <u>11-15-67 TO 11-21-67</u>			
<b>22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT.</b> <u>None</u>				<b>23. MEDICAL CERTIFICATION</b> 19A. DATE OF OPERATION <u>11-15-67</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Mitral Stenosis</u> 20A. AUTOPSY? (Yes or No) <u>yes</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>no</u> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>University Hosp</u> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>University Hosp.</u> 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>11 21 67</u> 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> 21F. HOW DID INJURY OCCUR? <u>DURING ANESTHESIA</u>			
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>11-12</u> <u>1967</u> <b>to</b> <u>11-21</u> <u>1967</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>11-21</u> <u>1967</u> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				<b>23A. SIGNATURE</b> <u>Chester M. Anderson, M.D.</u> <b>23B. DATE SIGNED</b> <u>11-21-67</u>			
<b>23C. PHYSICIAN'S NAME (Type)</b> <u>Chester M. Anderson, M.D.</u>				<b>23D. ADDRESS</b> <u>Univ. Hospital</u>			
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>24B. DATE</b> <u>11-25-67</u>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <u>Salisbury Cemetery</u>		<b>24D. LOCATION</b> (City, town, or county) (State) <u>Salisbury, Somerset Co PA</u>	
<b>25A. DATE RECEIVED BY HEALTH DEPT.</b> <u>NOV 24 1967</u>		<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Taylor</u>		<b>25C. FUNERAL DIRECTOR</b> ADDRESS <u>Burgess Funeral Home 3631 Falls Rd</u> <u>By N. Ward</u>		<b>25D. ADDRESS</b> <u>3631 Falls Rd</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11253				BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 67 11253		
M.E. CASE NO. M.				C.				
1. NAME OF DECEASED (Type or Print) <b>Margaret Lockman</b>				2. DATE AND HOUR OF DEATH <b>11/21/67</b>   <b>1:50</b> p. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>43 SOUTH BALTIMORE GENERAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>522 N. Potomac Street</b>				
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>10/22/89</b>	9. AGE (In years last birthday) <b>78</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			13. FATHER'S NAME <b>Frederick Porsinger</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Walker</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-03-9214D</b>		17. INFORMANT ADDRESS <b>Lillian E. Walstrum 7420 Old Harford Road</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Shock 2° Septicemia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>7 d.</b>				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CONGESTIVE HEART FAILURE</b>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <b>11/20/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Incarcerated femoral hernia</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (X) (this hospital) attended the deceased from <b>11/20/67</b> 19 to <b>11/21/67</b> 19, that (X) (we) last saw the deceased alive on <b>11/21/67</b> 19 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>J. Butchart</b>		
23B. DATE SIGNED <b>11/21/67</b>		23C. PHYSICIAN'S NAME (Type) <b>J. BUTCHART, M.D.</b>		23D. ADDRESS <b>S.B.G.H. - 1213 Light St.</b>		23E. DATE SIGNED		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Nov 25 67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Taylor Avenue Balto Md</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 24 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Tarkenton</b>		25C. FUNERAL DIRECTOR <b>The Dippel Bros Inc 7110 Belair Rd</b>		25D. ADDRESS		





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

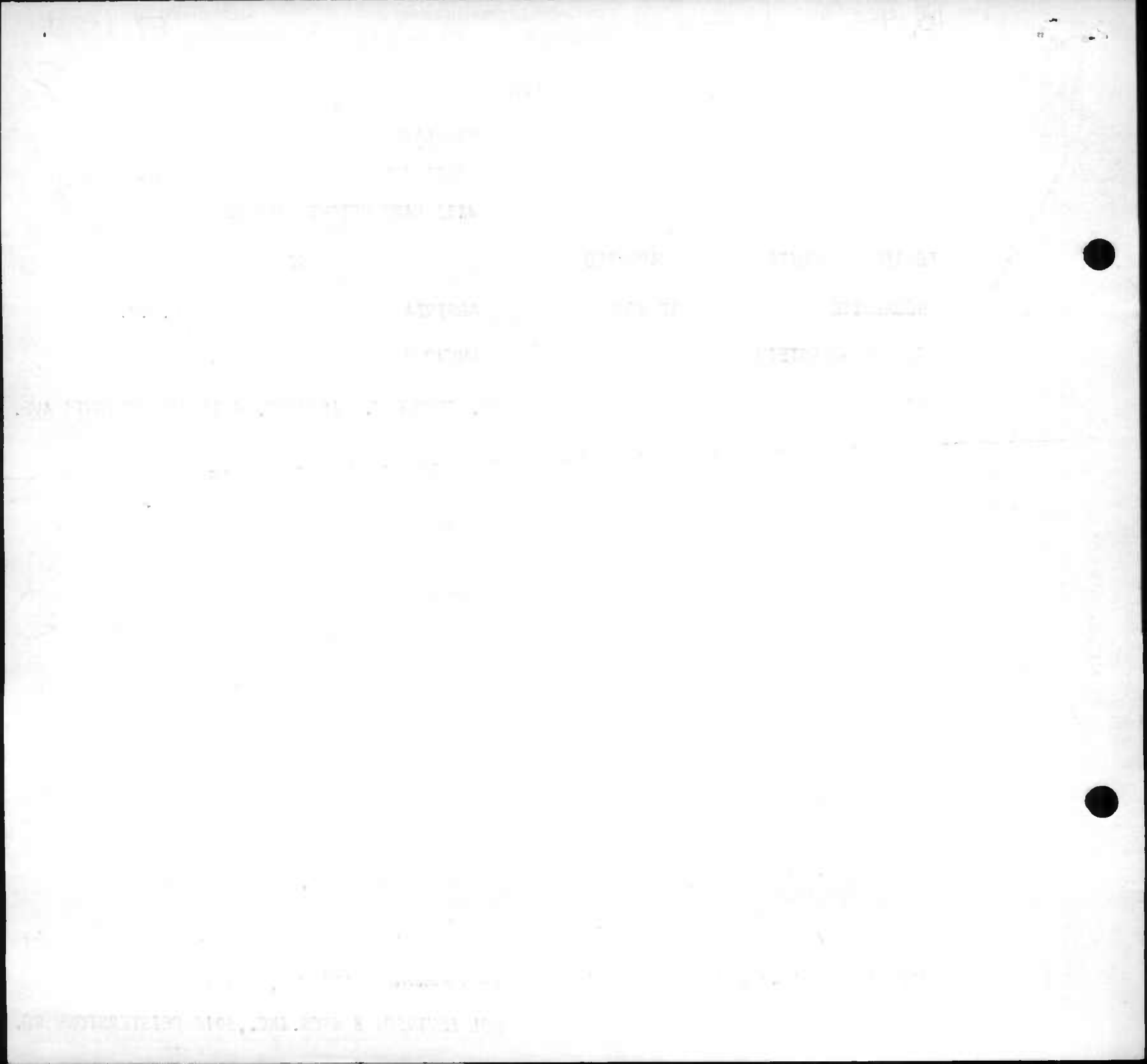
BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 11254	
U-526		67 11254		CERTIFICATE OF DEATH							
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Nathan Henry Unger</i>				2. DATE AND HOUR OF DEATH <i>NOVEMBER 20 / 67 6:30 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>3701 Clarke Lane Apt B</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>27-20</i> D. STREET ADDRESS (If rural, give location) <i>3701 Clarke Lane - Apt B</i>							
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>May 31, 1898</i>	9. AGE (In years lost birthday) <i>69</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Millinery</i>		11. BIRTHPLACE (State or foreign country) <i>New York City</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Frederick Unger</i>		14. MOTHER'S MAIDEN NAME <i>Maudie ?</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Beatrice Unger - 3701 Clarke Lane Apt B</i>		ADDRESS <i>Apt B</i>	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>myocardial infarct</i> (B) <i>Coronary artery disease</i> (C)				INTERVAL BETWEEN ONSET AND DEATH <i>43 days</i> <i>4 years</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <i>3/11</i> 19 <i>65</i> to <i>11/20</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>11/15</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>A. H. K. KODONY</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>NOV. 21 / 67</i>							
23C. PHYSICIAN'S NAME (Type) <i>A. LEWIS KODONY</i>		23D. ADDRESS <i>3900 N. CHARLES ST.</i>									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Nov 22 / 67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore Hebrew</i>		24D. LOCATION (City, town, or county) (State) <i>Reisterstown, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 24 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>Sal Lerner</i>		ADDRESS <i>6010 Rest Road</i>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>B-451</span> <span>67 11255</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>Registered No.</span> <span>67 11255</span> </div>	
BIRTH NO. <span style="font-size: 1.2em;">1</span>		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">BLUMBERG, MARION ANNY</span>		11/20/67 12:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">42 OF BALTIMORE</span>		A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE</span>		D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">4832 PARK HEIGHTS AVENUE</span>	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
<span style="font-size: 1.2em;">FEMALE</span>	<span style="font-size: 1.2em;">WHITE</span>	<span style="font-size: 1.2em;">MARRIED</span>	<span style="font-size: 1.2em;">62</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
<span style="font-size: 1.2em;">HOUSEWIFE</span>		<span style="font-size: 1.2em;">AT HOME</span>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<span style="font-size: 1.2em;">JOSEPH BUERSTEIN</span>		<span style="font-size: 1.2em;">UNKNOWN</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<span style="font-size: 1.2em;">NO</span>			
17. INFORMANT		ADDRESS	
<span style="font-size: 1.2em;">DR. JEROME J. BLUMBERG, 4832 PARK HEIGHTS AVE.</span>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
<span style="font-size: 1.2em;">420.11</span>		<span style="font-size: 1.2em;">MYOCARDIAL INFARCTION</span>	
ANTECEDENT CAUSES		<span style="font-size: 1.2em;">3 days</span>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<span style="font-size: 1.2em;">ASHD</span>	
		<span style="font-size: 1.2em;">? years</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<span style="font-size: 1.2em;">? G.I. hemorrhage</span>	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<span style="font-size: 1.2em;">0</span>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">11/18</span> 19 <span style="font-size: 1.2em;">67</span> to <span style="font-size: 1.2em;">11/20</span> 19 <span style="font-size: 1.2em;">67</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">11/20</span> 19 <span style="font-size: 1.2em;">67</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.2em;">Richard Katon</span> M.D.			23B. DATE SIGNED <span style="font-size: 1.2em;">11/20/67</span>
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">RICHARD KATON</span> M.D.			23D. ADDRESS <span style="font-size: 1.2em;">SINAI HOSPITAL OF BALTIMORE</span>
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
<span style="font-size: 1.2em;">BURIAL</span>	<span style="font-size: 1.2em;">11-22-67</span>	<span style="font-size: 1.2em;">ARLINGTON - CHICK AMUND</span>	<span style="font-size: 1.2em;">BALTIMORE, Maryland</span>
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">NOV 24 1967</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fisher</span>	
		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">SQL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD.</span>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# CERTIFICATE OF DEATH

Registered No.

67 11256

VS 150-REV. 1/1/65

YANKS 20/12

FRIDAY 11/12

W

8-57-1112

12

ADU ~~RECEIVED~~ ~~RECEIVED~~

11/12/12

11/12/12

2012-12-11/12/12

11/12/12

11/12/12

11/12/12

11/12/12

67 11257

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11257

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LYDIA

2. DATE AND HOUR PRONOUNCED DEAD

November 19, 1967 | 3:40 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

MARILYN A. COLLIER

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street  
address or location)

12-1-67

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2217 South Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

AUGUST 11, 1928

9. AGE (In years  
last birthday)

38 39

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

PITTSBURGH, PENNSYLVANIA

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HARRY GERSTEIN

14. MOTHER'S MAIDEN NAME

ETHEL -?- MILLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

DR. JEROME COLLIER, 2217 SOUTH ROAD #21209

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Multiple traumatic injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

Holiday Inn

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Lombard and Howard Sts.

21D. TIME  
OF INJURY  
(APPROX.)

11

19

67

3:10p.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subject was found on balcony (app. jumped)

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 20, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

REMOVAL

23B. DATE

11-20-67

23C. NAME OF CEMETERY or CREMATORY

GRACELAND MEMORIAL PARK

23D. LOCATION

(City, town, or county)

(State)

DADE COUNTY, FLORIDA

24A. DATE REC'D BY HEALTH DEPT.

NOV 24 1967

24B. NAME OF REGISTRAR

Robert E. Fairburn

24C. FUNERAL DIRECTOR

SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD.

ADDRESS

Letter Brother of Deceased, Richard E.  
Gerstein, State Attorney of Miami, Florida  
1 2-1-67 M.H.

WILLEY FORGE

RAY CONSENT

WILLEY FORGE

WILLEY FORGE

WILLEY FORGE

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-600		67 11258		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11258	
<b>CERTIFICATE OF DEATH</b>							
1. NAME OF DECEASED (Type or Print) <i>MRS. ANNIE SCHERR</i>				2. DATE AND HOUR OF DEATH <i>11-20-67 14:53 A</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>The Johns Hopkins Hospital</i> <i>33</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>3508 Grantley Rd.</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>11/15/85</i>	9. AGE (In years last birthday) <i>82</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>RUSSIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>BERNARD David Smith</i>				14. MOTHER'S MAIDEN NAME <i>TOBY Sarah Weiner</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>MR. PERCY SCHERR, 3600 GRANTLEY ROAD #21215</i>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Acute Myocardial Inf.</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 Hrs</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Atherosclerosis of Coronary Arteries</i> <i>years</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>L.V.H.</i>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <i>11-20-67</i> to <i>11-20-67</i> that (1) (we) last saw the deceased alive on <i>11-20-67</i> and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Robert A. Cordes</i> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>11-20-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Robert A. Cordes</i>				23D. ADDRESS M.D. <i>The Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>11-21-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>HAR ZION TIFERETH ISRAEL</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 24 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR <i>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD</i>		ADDRESS	

W. G. 2

W. G. 2

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W. G. 2

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-625		67 11259		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 67 11259	
BIRTH NO. 67 11259				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>KIRSCHNER, LIBBY</b>				2. DATE AND HOUR OF DEATH <b>9:55 PM 11/19/67</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <b>42 SINAI Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3504 Wild Cherry Rd.</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>9/29/31</b>	9. AGE (In years last birthday) <b>36</b>	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JACOB FEIT</b>				14. MOTHER'S MAIDEN NAME <b>TILLIE MAGAZINER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>MR. BERNARD KIRSCHNER, 3504 WILD CHERRY RD. #7</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>170X1 METASTATIC ADENO-CARCINOMA of the Breast</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(B) DUE TO Metastases to brain + vertebral column</b> <b>(C) hypercalcemia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs +</b>			
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (This hospital) attended the deceased from <b>10/1/67</b> to <b>11/19/67</b> , that (1) (we) last saw the deceased alive on <b>11/19/67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We did) (did not) view the body after death.							
23A. SIGNATURE <b>Alan F. Wolf</b>				23B. DATE SIGNED <b>11/29/67</b>			
23C. PHYSICIAN'S NAME (Type) <b>ALAN F. WOLF</b>				23D. ADDRESS <b>C/O SINAI Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11-21-67</b>		24C. NAME of CEMETERY or CREMATORY <b>MIKRO KODESH</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 24 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 1.5em;">A-536</span> 67 11260				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11260	
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">ISAAC AMDUR</span>				<b>2. DATE AND HOUR OF DEATH</b> NOVEMBER 20, 1967 <span style="float: right;">P M.</span>			
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">JEWISH CONVELESANT HOME</span>				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE</span> <b>D. STREET ADDRESS</b> (If rural, give location) <span style="font-size: 1.2em;">3802 FAIRVIEW AVENUE</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">MALE</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">WHITE</span>	<b>7. MARRIED, NEVER MARRIED</b> WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">WIDOWED</span>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">94</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">94</span>	<b>If Under 1 Yr.</b> Months: Days: Hours: Min.	<b>If Under 24 Hrs.</b> Hours: Min.	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">TAILOR</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">HENRY SONABORN</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">LUTHUANIA</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">CARL AMDUR</span>				<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">MARY ?"</span>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> ADDRESS <span style="font-size: 1.2em;">MRS. CELE DAVISON, 3409 TANEY ROAD</span>			
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenie, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">#42X1</span>				<b>CAUSE OF DEATH</b> (A) <span style="font-size: 1.2em;">Pneumonia &amp; arteriosclerosis</span> (B) <span style="font-size: 1.2em;">of heart &amp; kidneys</span> (C)		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">4 yrs</span>	
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>							
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">no</span>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">9/65</span> <b>19</b> <b>to</b> <span style="font-size: 1.2em;">11/20/67</span> <b>19</b> , <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">11/20</span> <b>19</b> <b>67</b> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>							
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Milton Kirsch</span>				<b>M.D.</b> Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">11/20/67</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">MILTON KIRSCH</span>				<b>23D. ADDRESS</b> M.D. <span style="font-size: 1.2em;">4000 W. NORTHERN PKWY.</span>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">BURIAL</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">11-21-67</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">ANSHE EMUNAH AITZ CHAIM</span>		<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">BALTIMORE, MARYLAND</span>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">NOV 22 1967</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Jankovsky</span>		<b>25C. FUNERAL DIRECTOR</b> ADDRESS <span style="font-size: 1.2em;">SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD</span>			

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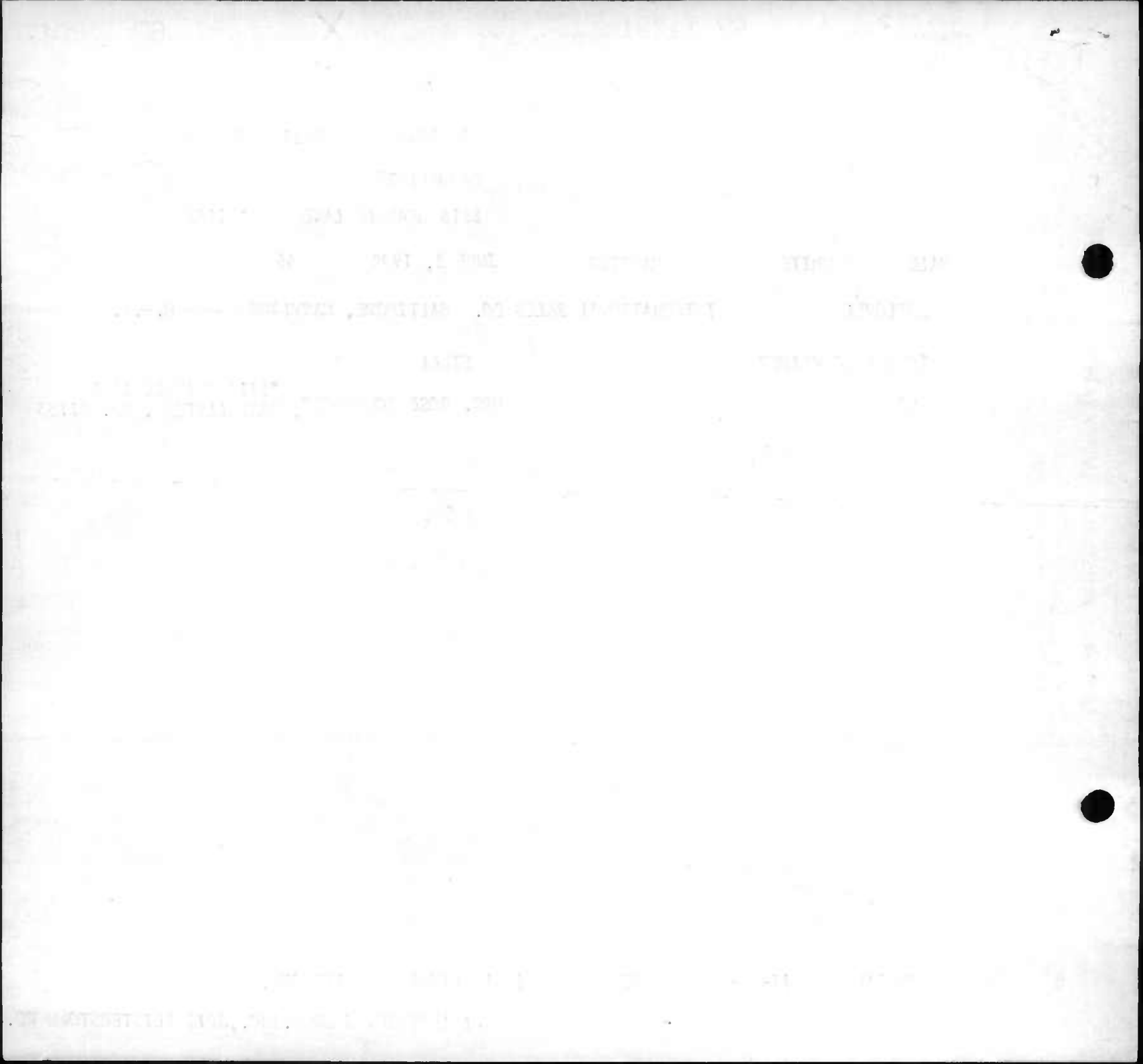
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>67 11261</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 11261</b>	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>Earl Schneider</b>		2. DATE AND HOUR OF DEATH <b>11/20/67 4:27 PM</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>4200A Sinai Hosp of Baltimore</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE Co</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>RANDALLSTOWN 53-00</b> D. STREET ADDRESS (If rural, give location) <b>8616 BRAMBLE LANE #21133</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JUNE 2, 1902</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>EMPLOYEE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>INTERNATIONAL SALES CO. BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ISRAEL SCHNEIDER</b>			14. MOTHER'S MAIDEN NAME <b>ETHEL ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>MRS. ROSE SCHNEIDER, *8616 BRAMBLE LANE RANDALLSTOWN, MD. 21133</b>	
18. <b>443X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Cerebrovascular Accident</b> (B) <b>ASCVD</b> (C) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>unknown</b> <b>unknown</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Uremia</b>		<b>unknown</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Kenneth Wetcher</b> M.D.				23B. DATE SIGNED <b>11/20/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>KENNETH WETCHER</b> M.D.				23D. ADDRESS <b>Sinai Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11-22-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>CHIZUK AMUNO (ARLINGTON)</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>NOV 24 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD.</b>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 11262	
67 11262				67 11262	
BIRTH NO.				Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>Marcella Slaviskas</u>				2. DATE AND HOUR OF DEATH <u>1-20-67</u> <u>7:45 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u>				A. STATE <u>Maryland</u> B. COUNTY	
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
				D. STREET ADDRESS (If rural, give location) <u>Bolton Hill Nursing Home</u>	
5. SEX <u>♀</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED</u> (specify)	8. DATE OF BIRTH <u>2-03-90</u>	9. AGE (In years last birthday) <u>77</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>			11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>---</u>	17. INFORMANT <u>Alvera Page (Daughter)</u>	
					ADDRESS <u>12 Over Ridge Court</u>
18. <u>609 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Septicemia</u> (A) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Urinary Tract Infection</u> (B) DUE TO				<u>?</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>II</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11-25-67</u> to <u>11-20-67</u> , that (I) (we) last saw the deceased alive on <u>11-20-67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William L. Boddie</u> M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <u>Maryland General Hospital</u> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11/23/67</u>		24C. NAME of CEMETERY or CREMATORY <u>PARKWOOD CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>PARKVILLE MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 24 1967</u>			
25B. NAME OF REGISTRAR <u>R. L. S. J. O. S.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>ULLRICH FUNERAL HOME 4210 BELAIR</u>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
67 11263		67 11263		67 11263	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>PAULINE JANZEN</b>		2. DATE AND HOUR OF DEATH <b>11/19/67</b>   <b>4:08 P. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE UNION MEMORIAL HOSPITAL</b>		A. STATE <b>MARYLAND</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>2802 STRATHMORE AVE</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>06-30-96</b>	9. AGE (In years last birthday) <b>71</b>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE-AT HOME</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>		13. FATHER'S NAME <b>ADOLPH WEWERKA COI</b>			
14. MOTHER'S MAIDEN NAME <b>MARIE RICHTER (D)</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>720-46-9608</b>		17. INFORMANT <b>MARGUERITE MOLTE</b> ADDRESS <b>701 St. John St. BALT. MD</b>			
18. <b>420.11</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>CARDIAC ARREST</b> DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>MYOCARDIAL INFARCTION</b> DUE TO			
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (s) (this hospital) attended the deceased from <b>11-17</b> 19 <b>67</b> to <b>11-19</b> 19 <b>67</b> , that (s) (we) last saw the deceased alive on <b>11-19</b> 19 <b>67</b> and that in (s) (our) opinion death occurred on the date and hour and from the causes stated above. (s) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Cesar F. Climaco</b>				23B. DATE SIGNED <b>11-19-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>CESAR F. CLIMACO</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b> <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/23/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>LOUDON PARK</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 24 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Sankey, JR</b>	
25C. FUNERAL DIRECTOR <b>ULLICH FUNERAL HOME - 4216 BELAIR</b>					

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11/10/54

11/10/54

THE UNION MEDICAL HOSPITAL

205 STATE STREET

BALTIMORE

MARYLAND

ROBERT WHITE

CL-30-10 21

ROBERT WHITE

BALTIMORE

MARYLAND

ROBERT WHITE

BALTIMORE

BALTIMORE

CARDINAL

11/10/54

INDICATOR

Car & Clinic

Car & Clinic

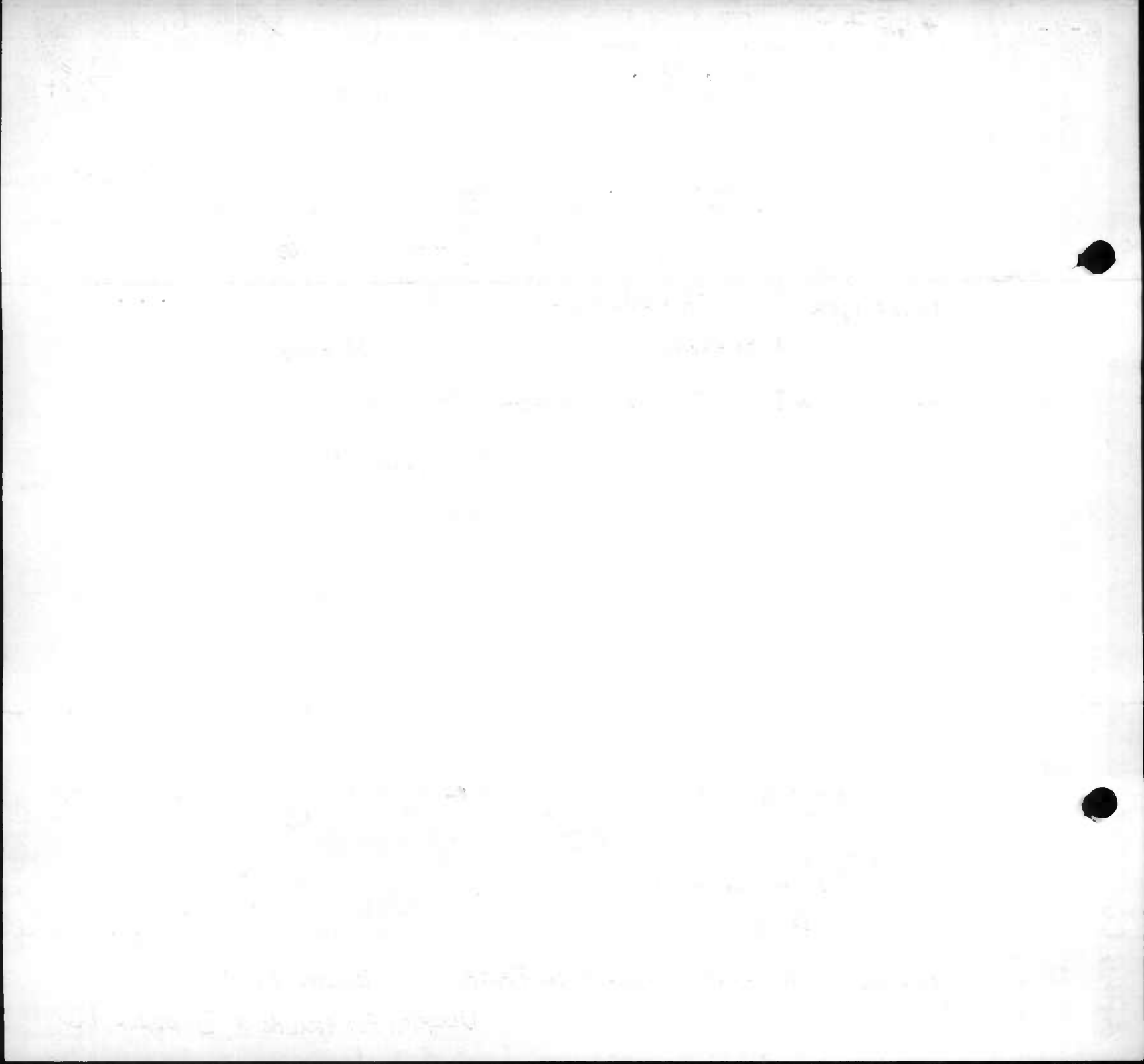
THE UNION MEDICAL HOSPITAL

49-66-33  
ME

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

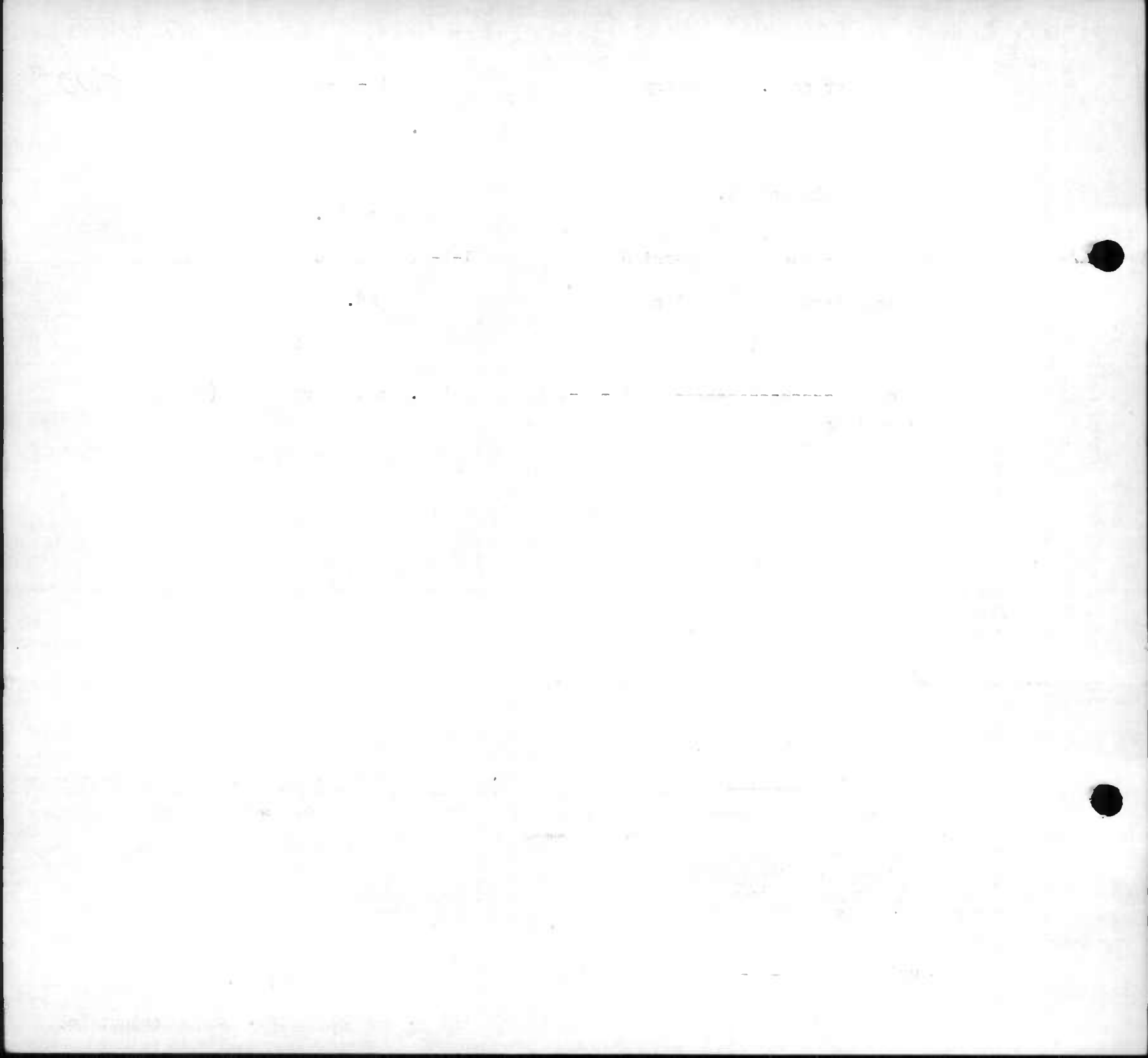
BIRTH NO. <b>W-520</b> 67 11264				BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. <b>67 11264</b>	
M.E. CASE NO. <b>Wienecke John E</b>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Wienecke, John E.</b>		2. DATE AND HOUR OF DEATH <b>11-21-67</b> <b>7<sup>30</sup> A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVE.</b> <b>BALTIMORE MARYLAND 21224</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balt Co.</b> D. STREET ADDRESS (If rural, give location) <b>1804 SNYDER AVE. 21222</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>9-9-1898</b>	9. AGE (In years) lost <b>69</b>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHIPFITTER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SHIP BUILDING</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF <b>U.S.A.</b>	
13. FATHER'S NAME <b>FREDERICK WIENECKE</b>			14. MOTHER'S MAIDEN NAME <b>LILLIAN MURPHY</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWT</b>		16. SOCIAL SECURITY NO. <b>215-12-0434</b>		17. INFORMANT <b>BCH: RECORDS 4940 EASTERN AVE</b> <b>BALTIMORE MARYLAND 21224</b>		ADDRESS	
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b> <b>CVA.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>7-8-67</b> 19 to <b>11-21</b> 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>11-20</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>P. Desmond</b> M.D.				23B. DATE SIGNED <b>11-21-67</b>			
23C. PHYSICIAN'S NAME (Type) <b>P. Desmond</b> M.D.				23D. ADDRESS <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVE BALTIMORE, MARYLAND 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11-24-67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>GARDEN OF FAITH</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. CO., MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 24 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR <b>ULLRICH FUNERAL HOME, DUNDALK, MD.</b>			



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">67 11265</span>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <span style="font-size: 1.5em;">67 11265</span></span> <span style="font-size: 1.5em;">CERTIFICATE OF DEATH</span> </div>					
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Charles R. Montgomery</span>			<b>2. DATE AND HOUR OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span>11-20-67</span> <span>6:00 <sup>a</sup> M.</span> </div>		
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  <div style="display: flex;"> <div style="flex: 1;"> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>   <div style="font-size: 1.5em;">00</div> </div> <div style="flex: 1;">                 (If not in hospital or institution, give street address or location)   <span style="font-size: 1.2em;">3616 Ash St.</span> </div> </div>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY _____  <b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span> <b>D. STREET ADDRESS</b> (If rural, give location) <span style="font-size: 1.2em;">3616 Ash St.</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">White</span>	<b>7. MARRIED, NEVER MARRIED</b> WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Married</span>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">1-1-02</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">65</span>	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Stock Clerk</span>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Black&amp;Decker</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Md.</span>
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">?</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">?</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">215-07-6426</span>	<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Hazel B. Montgomery</span>		
			<b>ADDRESS</b> <span style="font-size: 1.2em;">(same)</span>		
<b>18. CAUSE OF DEATH</b> <div style="display: flex;"> <div style="flex: 2;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   <span style="font-size: 1.5em;">203 X I</span>  <span style="font-size: 1.2em;">multiple myeloma</span> </div> <div style="flex: 1;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <span style="font-size: 1.2em;">2 years</span> </div> </div>					
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (nailly medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">June 14</span> <span style="font-size: 1.2em;">1965</span> <b>to</b> <span style="font-size: 1.2em;">Nov. 20</span> <span style="font-size: 1.2em;">1967</span> , <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">Nov. 20</span> <span style="font-size: 1.2em;">1967</span> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Reuben Hoffman</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">11-22-67</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">REUBEN HOFFMAN</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">846 W. 36<sup>th</sup> St., BALTO, MD.</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>	<b>24B. DATE</b> <span style="font-size: 1.2em;">11-22-67</span>	<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Lorraine</span>	<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>		
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">NOV 24 1967</span>		<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Paul E. Fickens</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Paul E. Chenoweth</span>	
				<b>ADDRESS</b> <span style="font-size: 1.2em;">3rd. 3617 Chestnut Ave</span>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. M.E. CASE NO.		67 11266 <b>CERTIFICATE OF DEATH</b>				Registered No. 67 11266			
1. NAME OF DECEASED (Type or Print) <b>HALL, Edward E.</b>					2. DATE AND HOUR OF DEATH <b>Nov. 21, 1967</b> <span style="float: right;">55 P.M.</span>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 4716 Parkside Drive</b>					A. STATE <b>Md.,</b> B. COUNTY <b>21206</b>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>				
					D. STREET ADDRESS (If rural, give location) <b>4716 Parkside Drive</b>				
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>8/11/97</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lithographer</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>American Can Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Douglas Hall</b>					14. MOTHER'S MAIDEN NAME <b>Roselind Sebold</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>215-09-7098</b>		17. INFORMANT ADDRESS <b>Grace McKay Hall, wife, above</b>				
18. <b>177X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Oedocarcinoma of Prostate</b>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)				
INTERVAL BETWEEN ONSET AND DEATH <b>18 Months</b>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Arteriosclerotic Cardiovascular Disease</b>									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>May 17</b> 19 <b>67</b> to <b>November 21</b> 19 <b>67</b> , that (I) <del>we</del> last saw the deceased alive on <b>November 18</b> 19 <b>67</b> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>we</del> (did) <del>not</del> view the body after death.									
23A. SIGNATURE <b>Jose Martinez MD</b>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <b>11/21/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOSE MARTINEZ MD</b>					23D. ADDRESS <b>Medical Arts Bldg</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/24/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 24 1967</b>			25B. NAME OF REGISTRAR <b>Robert E. Farley</b>			25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>			

Missionary Observations  
of the

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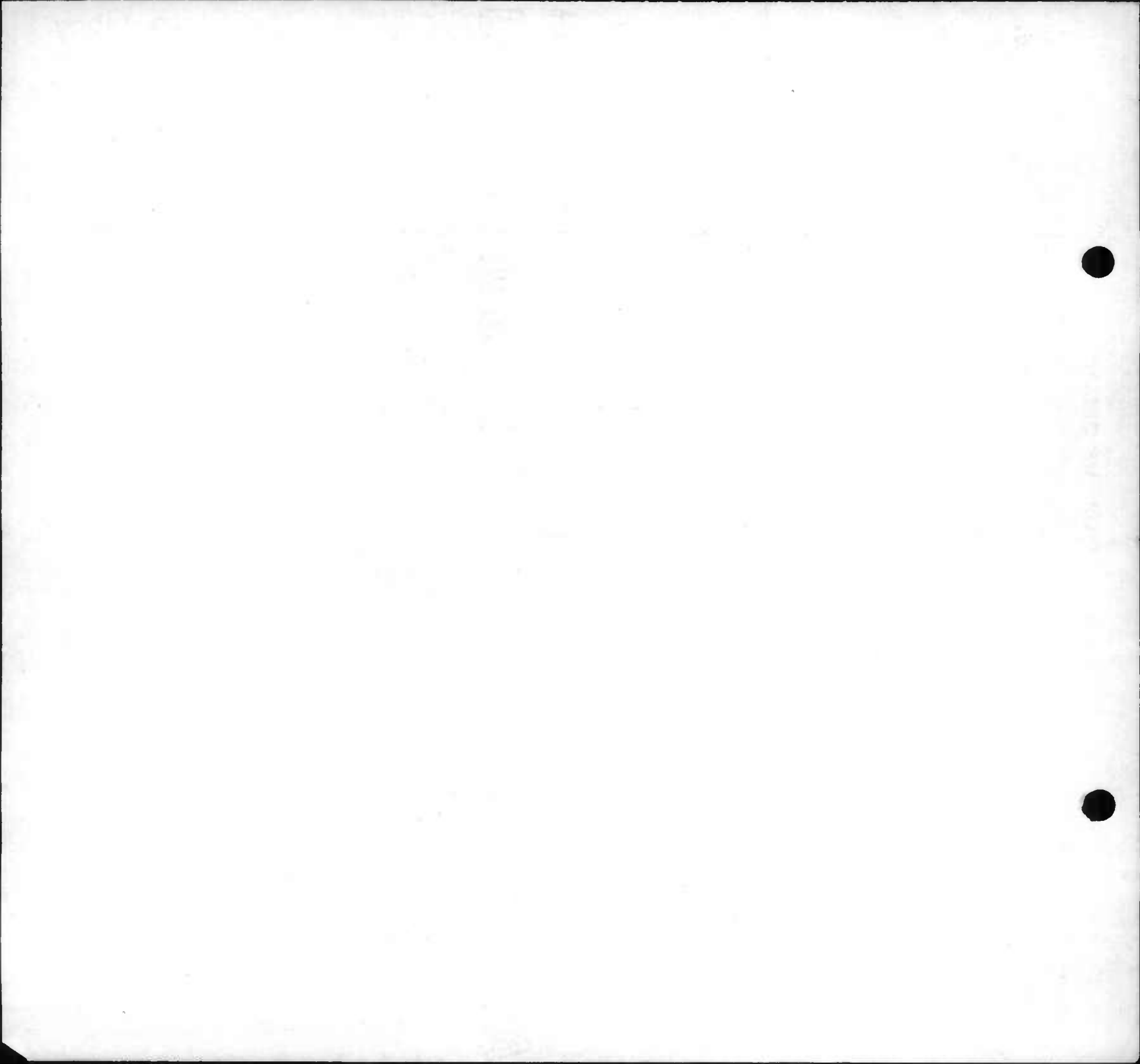
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**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 11267</u>
BIRTH NO. <u>67 11267</u>		<b>CERTIFICATE OF DEATH</b>		
M.E. CASE NO.		1. NAME OF DECEASED (Rosina) <u>ANNA A. SEIDENSTRICKER</u>		
2. DATE AND HOUR OF DEATH <u>11/21/67</u> <u>8:35 P.M.</u>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>FRANKLIN SQUARE HOSP</u> <u>36</u>		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>3219 KENTUCKY AVE 13</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED</u> (specify)	8. DATE OF BIRTH <u>9/22/84</u>	9. AGE (In years last birthday) <u>83</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ISAAC KERR</u>		
14. MOTHER'S MAIDEN NAME <u>ELIZABETH COOPER</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>217-14-0920F2</u>		
16. SOCIAL SECURITY NO. <u>217-14-0920F2</u>		17. INFORMANT <u>Helen A. Seidenstricker, grand-dght.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ABDOMINAL CARCINOMA</u>		INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) PRIMARY FOCUS UNDETERMINED		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <u>11/21/67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>11/8</u> 19 <u>67</u> to <u>11/21</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/21</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Thomas A. Alvero</u>		23B. DATE SIGNED <u>11/21/67</u>		23C. PHYSICIAN'S NAME (Type) <u>TOMAS A. ALVERO</u>
23D. ADDRESS <u>FRANKLIN SQUARE HOSPITAL</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>11/25/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Moreland Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 24 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

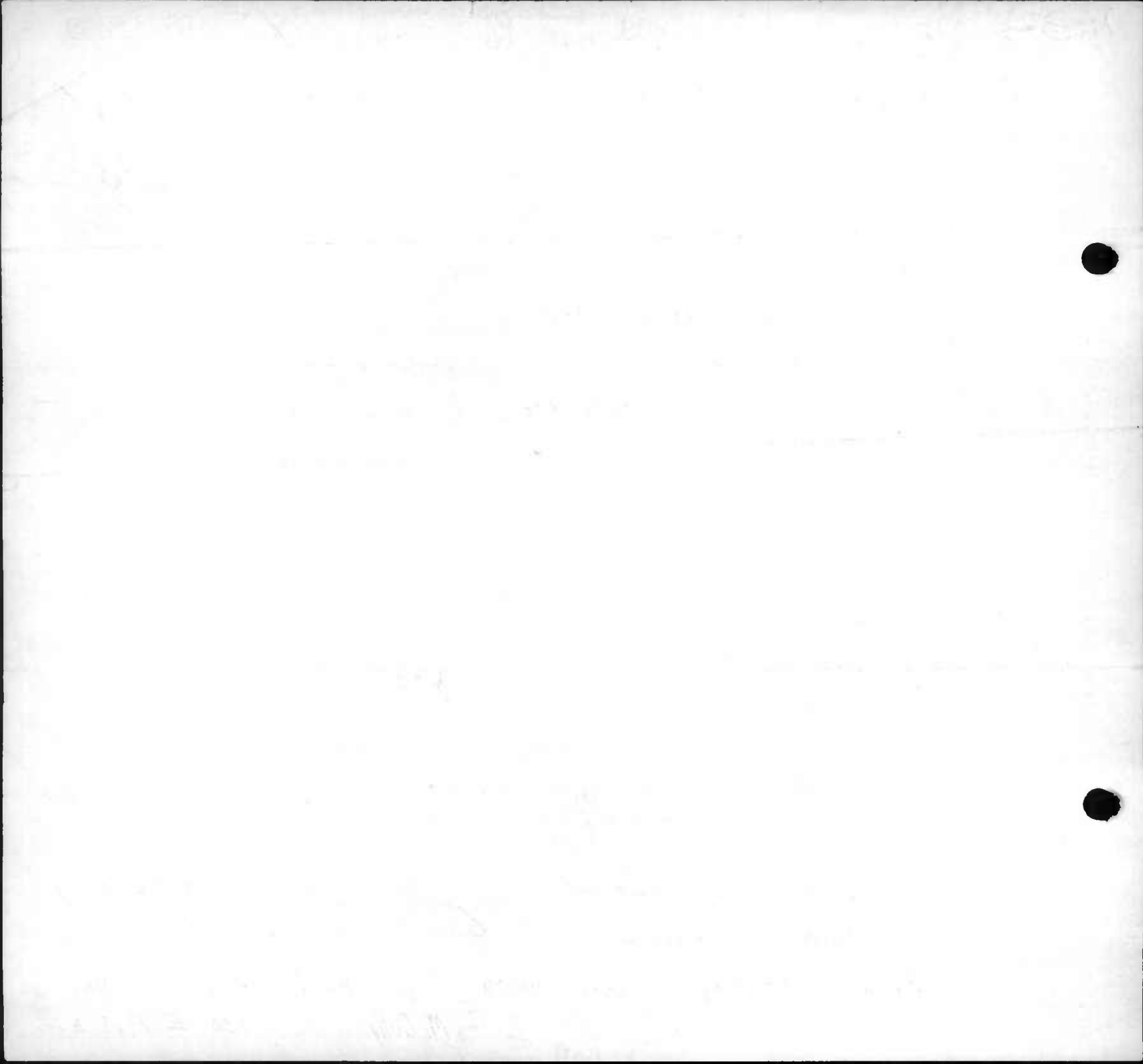
BALTIMORE CITY HEALTH DEPARTMENT				67 11268		67 11268	
BIRTH NO.				67 11268		67 11268	
M.E. CASE NO.				67 11268		67 11268	
1. NAME OF DECEASED (Type or Print) <u>Helen Schneider</u>				2. DATE AND HOUR OF DEATH <u>11-22-67 8:05</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 Bolton Hill convalescent Center</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balt.</u> D. STREET ADDRESS (If rural, give location) <u>7904 Aiken Ave. 21234</u>			
5. SEX <u>F</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>7-4-90</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months: <u>  </u> Days: <u>  </u>	If Under 24 Hrs. Hours: <u>  </u> Min: <u>  </u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Eatna Shirt Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Boss</u>				14. MOTHER'S MAIDEN NAME <u>Martina Vorsteg</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212 01 2973</u>		17. INFORMANT <u>Doris Berkemeier, dght, above</u>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>450.0 I</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Pneumonia</u> DUE TO (B) <u>Chronic Brain Syndrome</u> DUE TO (C) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>E. Ellsworth Cook</u> M.D.				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <u>E. Ellsworth Cook</u>				23D. ADDRESS M.D. <u>2431 Maryland Avenue</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/24/67</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 24 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farkas</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u>		ADDRESS <u>3331 Brehms Lane</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11269</b>	
BIRTH NO. <b>67 11269</b>				<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.				DATE AND HOUR OF DEATH <b>11/21/67 11:50 A.M.</b>	
1. NAME OF DECEASED (Type or Print) <b>Joseph S. HATCH</b>				2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>University of Maryland Hospital</b> <b>38</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>W</b>				D. STREET ADDRESS (If rural, give location) <b>517 W. Lombard St. Bldg. #1</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Boiler maker</b>		8. DATE OF BIRTH <b>2/9/16</b> 9. AGE (In years last birthday) <b>51</b>	
11. BIRTHPLACE (State or foreign country) <b>MD</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>112 09 7034</b>		17. INFORMANT <b>Friend</b> ADDRESS <b>817 W. Lombard St</b>	
18. <b>422.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ostherio, etc. It means the disease, injury or complication which caused death.) <b>Left middle cerebral Artery thrombosis</b>				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic cardiovascular disease + cerebrovascular disease</b>					
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>9/1/61</b> 19 <b>67</b> to <b>11/21</b> 19 <b>67</b> , that (2) (we) last saw the deceased alive on <b>11/21</b> 19 <b>67</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Sandra Z. Salen</b> M.D.				23B. DATE SIGNED <b>11/21/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Sandra Z. Salen</b>				23D. ADDRESS <b>University of MD Hosp</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-24-67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>	
24D. LOCATION (City, town, or county) <b>Glen Burnie, A. A. Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 24 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jarboe</b>		25C. FUNERAL DIRECTOR <b>McCully</b> ADDRESS <b>130 E. Fort Ave.</b>			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11270

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

67 11270

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LAURA LITTLE

2. DATE AND HOUR OF DEATH

NOV. 22, 1967 3:40 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

SINAI HOSPITAL OF  
42 BALTIMORE, INC.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

WEST VIRGINIA

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

WEST VIRGINIA V-45

D. STREET ADDRESS (If rural, give location)

972 WILCO

5. SEX

F

6. RACE

N

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
WIDOWED

8. DATE OF BIRTH

9/13/03

9. AGE (In years lost birthday)

64

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

D.C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Gate Myers

14. MOTHER'S MAIDEN NAME

Lulu Johnson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

James P. Little, Pegeton, D.C.

ADDRESS

18. 194X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

RESPIRATORY OBSTRUCTION  
& FAILURE

(A) DUE TO

THYROID CARCINOMATOSIS

(B) DUE TO

W/ METASTASIS TO THE

(C) DUE TO

LUNGS MEDIASTINUM,  
SKULL

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CONGESTIVE HEART FAILURE  
PNEUMONIA, LEFT LOWER LOBE

19A. DATE OF OPERATION

11/9/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

RESPIRATORY DIFFICULTY

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/7 19 67 to 11/22 19 67, that (I) (we) last saw the deceased alive on 11/22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

L M Chato

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11/22/67

23C. PHYSICIAN'S NAME (Type)

L M CHATO

M.D.

23D. ADDRESS

SINAI HOSPITAL OF BALTIMORE

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/26/67

24C. NAME OF CEMETERY OR CREMATORY

Oak Grove

24D. LOCATION

Blue Bell, D.C.

25A. DATE REC'D BY HEALTH DEPT.

NOV 24 1967

25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR

William Reese, II - Anna-Md.

ADDRESS

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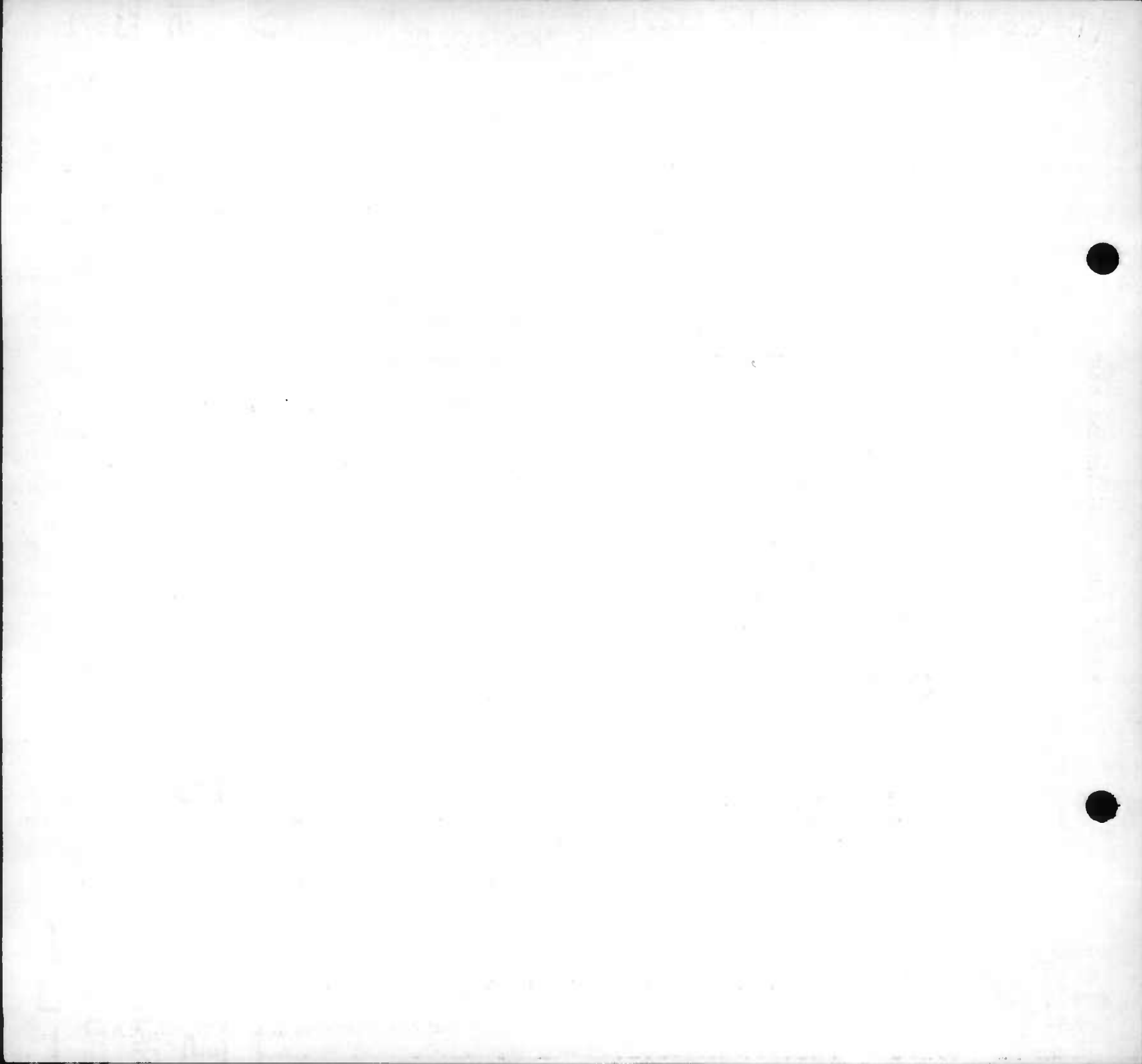
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Handwritten notes at the bottom of the page, including the phrase "THEY ARE NOT" and other illegible text.

# FUNERAL DIRECTOR: IMPORTANT

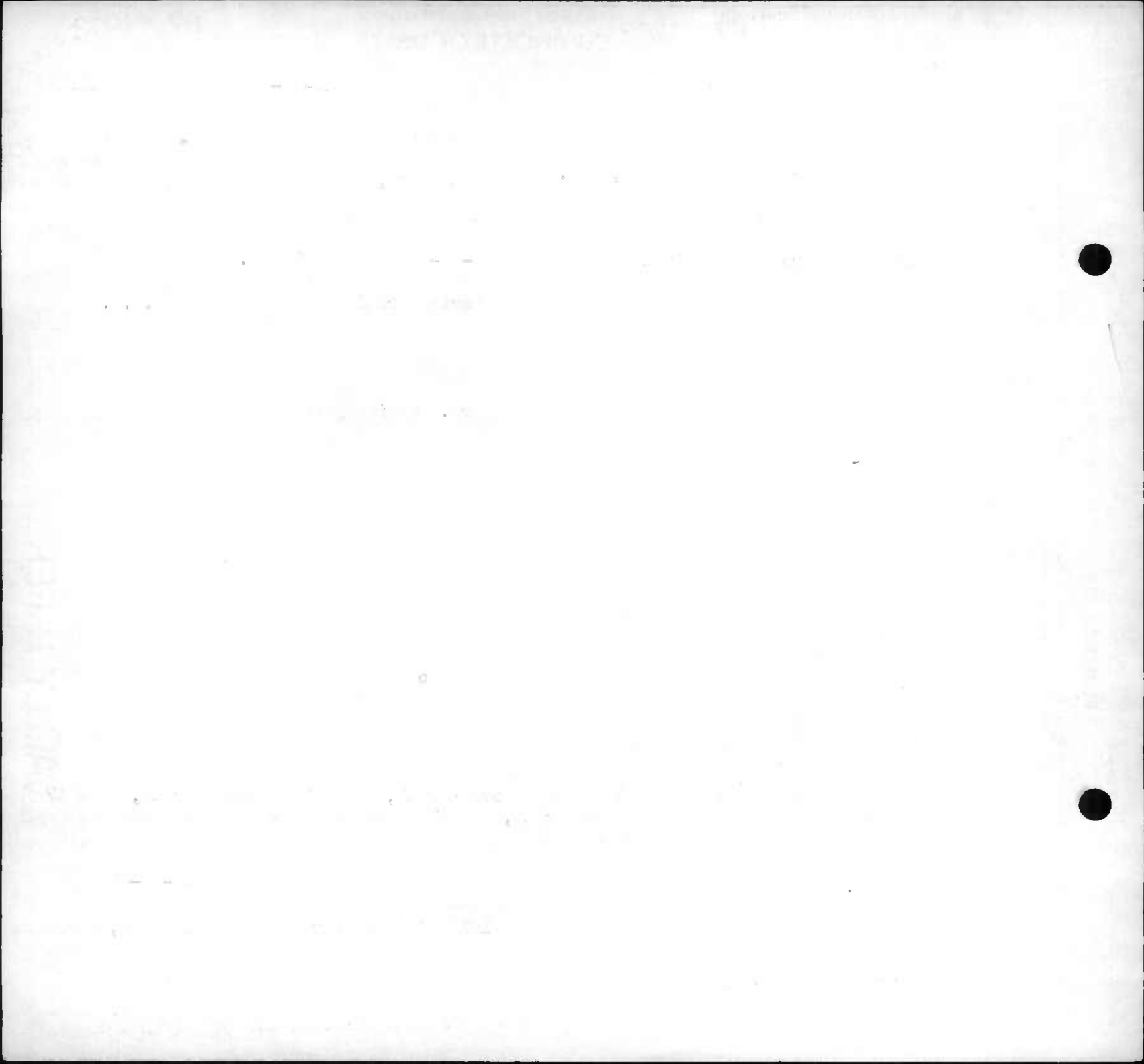
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 11271		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		67 11271	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>TERRY, JOHN Q.</b>				2. DATE AND HOUR OF DEATH <b>11 - 22 - 1967   5-15 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran hospital Baltimore MD 21216</b>					A. STATE <b>MD</b>				
(If not in hospital or institution, give street address or location)					B. COUNTY				
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					<b>Baltimore</b>				
D. STREET ADDRESS (If rural, give location)					<b>4506 Wakefield Road</b>				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
<b>Male</b>	<b>Colour</b>	<b>Married</b>	<b>4-12-38</b>	<b>29</b>					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
<b>Unemployed</b>			<b>-</b>		<b>Maryland</b>		<b>U. S. A.</b>		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
<b>John Q Terry, Sr</b>					<b>Dorothy M</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS
<b>no</b>					<b>Mrs Dorothy M Harris,</b>				<b>Same</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH
18. <b>345X1</b>					<b>Pneumonia</b>				<b>2 days</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) <b>multiple sclerosis</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
<b>0</b>		<b>-</b>		<b>-</b>		<b>-</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
<b>-</b>		<b>-</b>		<b>-</b>					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
<b>-</b>		<b>While At Work</b>		<b>-</b>					
22. I certify that (this hospital) attended the deceased from <b>11 - 21 - 1967</b> to <b>11 - 22 - 1967</b> , that (we) last saw the deceased alive on <b>11 - 22 - 1967</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) the body after death.									
23A. SIGNATURE <b>Batesa</b> <b>B. A. DESAI</b> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-22-67</b>		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS <b>Lutheran hospital</b>				
M.D.									
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
<b>Burial</b>		<b>11/25/67</b>		<b>Mt Auburn Cemetery</b>		<b>Baltimore Md</b>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
<b>NOV 24 1967</b>		<b>R. E. E. Jenkins</b>		<b>Adolphus Halstead</b>		<b>1206 W North Ave</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11272				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11272	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) Baxter Davis				2. DATE AND HOUR OF DEATH 11-19-67 11:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc.		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, 19-01			
				D. STREET ADDRESS (If rural, give location) 1305 Edmondson Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 5-28-1900	9. AGE (In years last birthday) 67 yrs.	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Hattie Dyson		ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I Myocardial Infarction				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from November 13, 19 67 to November 19, 19 67, that (I) (we) last saw the deceased alive on November 19, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. Tengco				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11-20-67	
23C. PHYSICIAN'S NAME (Type) Tengco				23D. ADDRESS M.D. 1514 Division Street Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/27/67		24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetry		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 24 1967		25B. NAME OF REGISTRAR R. E. Jenkins		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North A e		ADDRESS	



C-623

67 11273

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

67 11273

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Christian, Edward

2. DATE AND HOUR OF DEATH

21 November, 1967 9:40 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospitals

4940 Eastern Ave.

Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2821 W. Mulberry St. 21223 007

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

8-12-00

9. AGE (In years last birthday)

67

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Richard

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

233-24-2603

17. INFORMANT

ADDRESS

BCH: Records 4940 Eastern Ave. Baltimore, Md. # 21224

18. 465 XI

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY - LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.

(A) Respiratory Arrest

DUE TO

Pulmonary Embolus

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

ASCVD

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6 November 19 67 to 21 November 19 67. that (I) (we) last saw the deceased alive on 21 November 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Melvyn S. Tockman

M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

21 November '67

23C. PHYSICIAN'S NAME (Type)

Melvyn S. Tockman

M.D.

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Ave. Baltimore, Maryland #21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/24/67

24C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

24D. LOCATION (City, town, or county) (State)

A A County Md

25A. DATE REC'D BY HEALTH DEPT.

NOV 24 1967

25B. NAME OF REGISTRAR

Adolphus E. Tarkenton

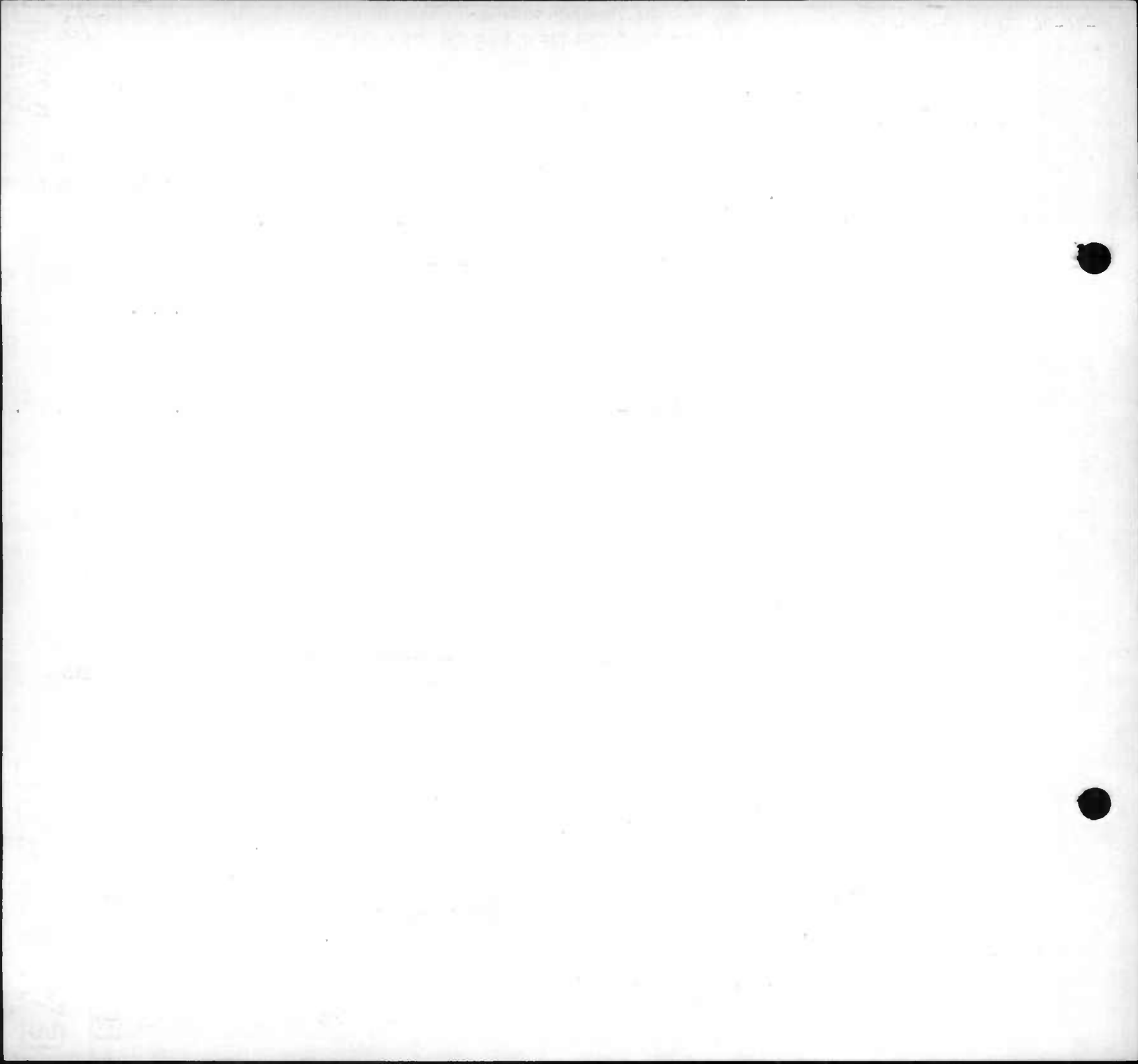
25C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

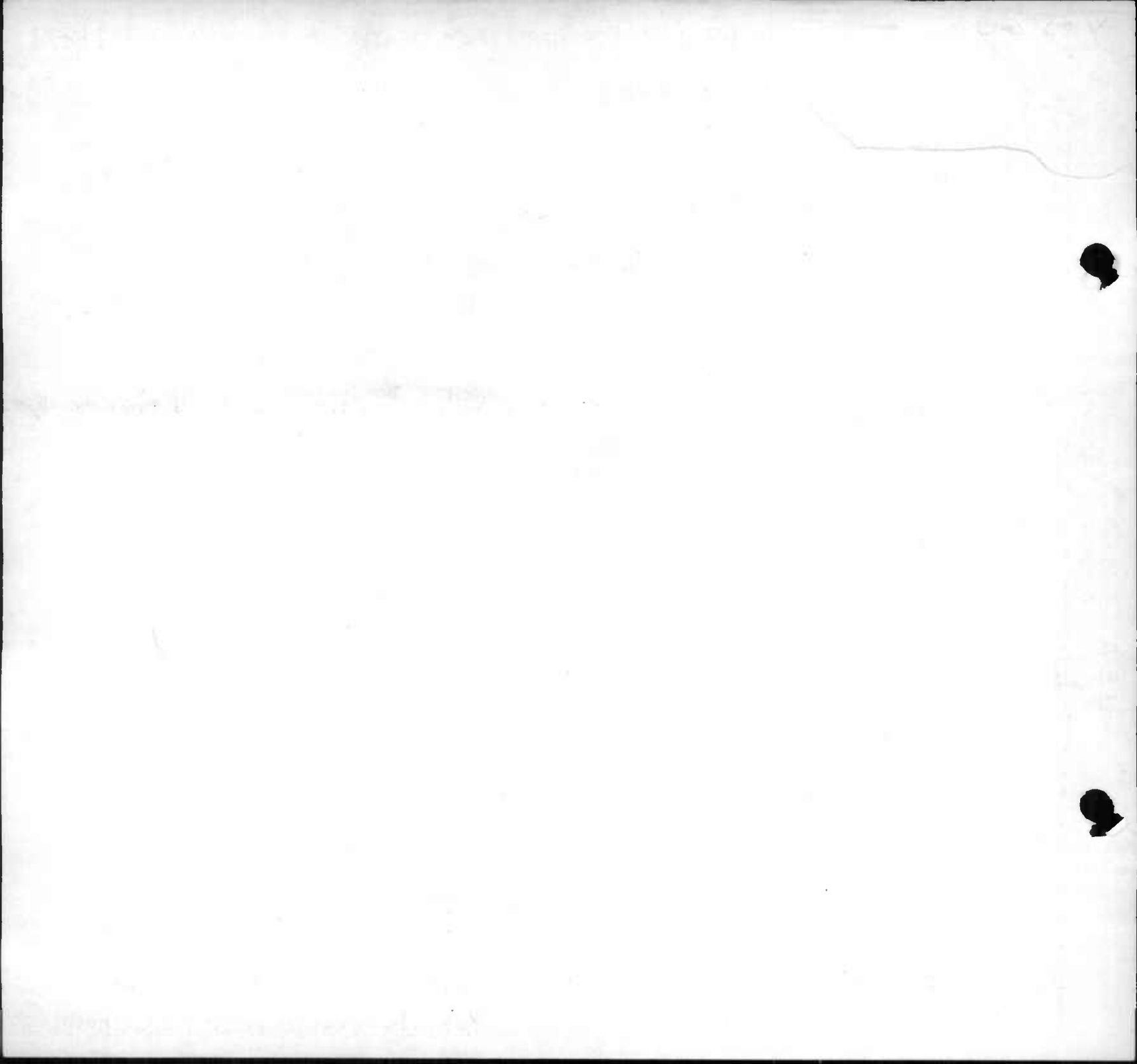




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No.			
67 11274				CERTIFICATE OF DEATH				398749 11274			
1. NAME OF DECEASED (Type or Print) <b>JAMES R. Young</b>				2. DATE AND HOUR OF DEATH <b>11/22/1967 8:10 P.M.</b>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY							
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTIMORE</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>							
(If not in hospital or institution, give street address or location)				D. STREET ADDRESS (If rural, give location) <b>3909 FAIRFAX ROAD.</b>							
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>12/14/18</b>	9. AGE (In years last birthday) <b>48</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>James Young</b>				14. MOTHER'S MAIDEN NAME <b>Edna Watkins</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-16-446</b>				17. INFORMANT ADDRESS <b>CAROLYN Courtney 3909 FAIRFAX Rd.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>INTERSTITIAL PULMONARY FIBROSIS</b>				(A) DUE TO							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.				(B) DUE TO							
(C) DUE TO											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <b>11/11/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Interstitial Pulmonary Fibrosis</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (this hospital) attended the deceased from <b>10/31/1967</b> to <b>11/22/1967</b> , that (I) last saw the deceased alive on <b>11/22/1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>[Signature]</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>11/22/67</b>			
23C. PHYSICIAN'S NAME (Type) <b>D. J. PRADHAN</b>				23D. ADDRESS <b>SINAI HOSPITAL OF BALTIMORE</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/27/67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR <b>Kelson Funeral Home</b>		ADDRESS <b>1348 Calhoun St.</b>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11275		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11275	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>CHARLES E. TOWNES</b>		2. DATE AND HOUR OF DEATH <b>11-21 '67 6:15 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Md. General Hospital</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
C. CITY OR TOWN (If outside city limits, write R.U.A. and give town) <b>Baltimore</b>		D. STREET ADDRESS (If rural, give location) <b>1367 Stricker St</b>		15-01	
5. SEX <b>Male</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Separated</b>	8. DATE OF BIRTH <b>1-28 '43</b>	9. AGE (In years last birthday) <b>24</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
13. FATHER'S NAME <b>Frank Townes</b>		14. MOTHER'S MAIDEN NAME <b>Paola Small</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>912-40-3042</b>		17. INFORMANT ADDRESS <b>PEARLA TOWNES 1367 Stricker St.</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>BRONCHOPNEUMONIA</b>		(A) DUE TO <b>PULMONARY EDEMA</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIOSCLEROTIC HEART DISEASE, E MYOCARDIAL INFARCT</b>		(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Yes</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-8</b> 19 <b>67</b> to <b>11-21</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-21</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Fredrik Bjornsson M.D.</b>				23B. DATE SIGNED <b>11-22 67</b>	
23C. PHYSICIAN'S NAME (Type) <b>F BJORNSSON M.D.</b>		23D. ADDRESS <b>Maryland General Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/25/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <b>2. Tolson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>F.H. Ter. 7. Kelson 1348 N. Calhoun St</b>			



1  
W-452

67 11276 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11276

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ANDREW WILLIAMS Jr.

2. DATE AND HOUR PRONOUNCED DEAD

November 23, 1967 6:40 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

CERTIFICATE AMENDED  
12-4-67

00

532 Laurens Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

5. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

6. STREET ADDRESS (If rural, give location)

532 Laurens Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

6-7-39

9. AGE (In years  
last birthday)

28

If Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Andrew Wms.

14. MOTHER'S MAIDEN NAME

Hazel Wms.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

216-36-8160

17. INFORMANT

Hazel Williams

ADDRESS

same

18. 199.2 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Dissected tumor (undifferentiated  
DUE TO adenocarcinoma primary site undetermined)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 23, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/27/67

23C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Pk.

23D. LOCATION

Arbutus, Maryland

24A. DATE REC'D BY HEALTH DEPT.

NOV 24 1967

24B. NAME OF REGISTRAR

Robert E. Fairley

24C. FUNERAL DIRECTOR

Kelson Funeral Home 1348 Calhoun St.

WELLY PONDGE

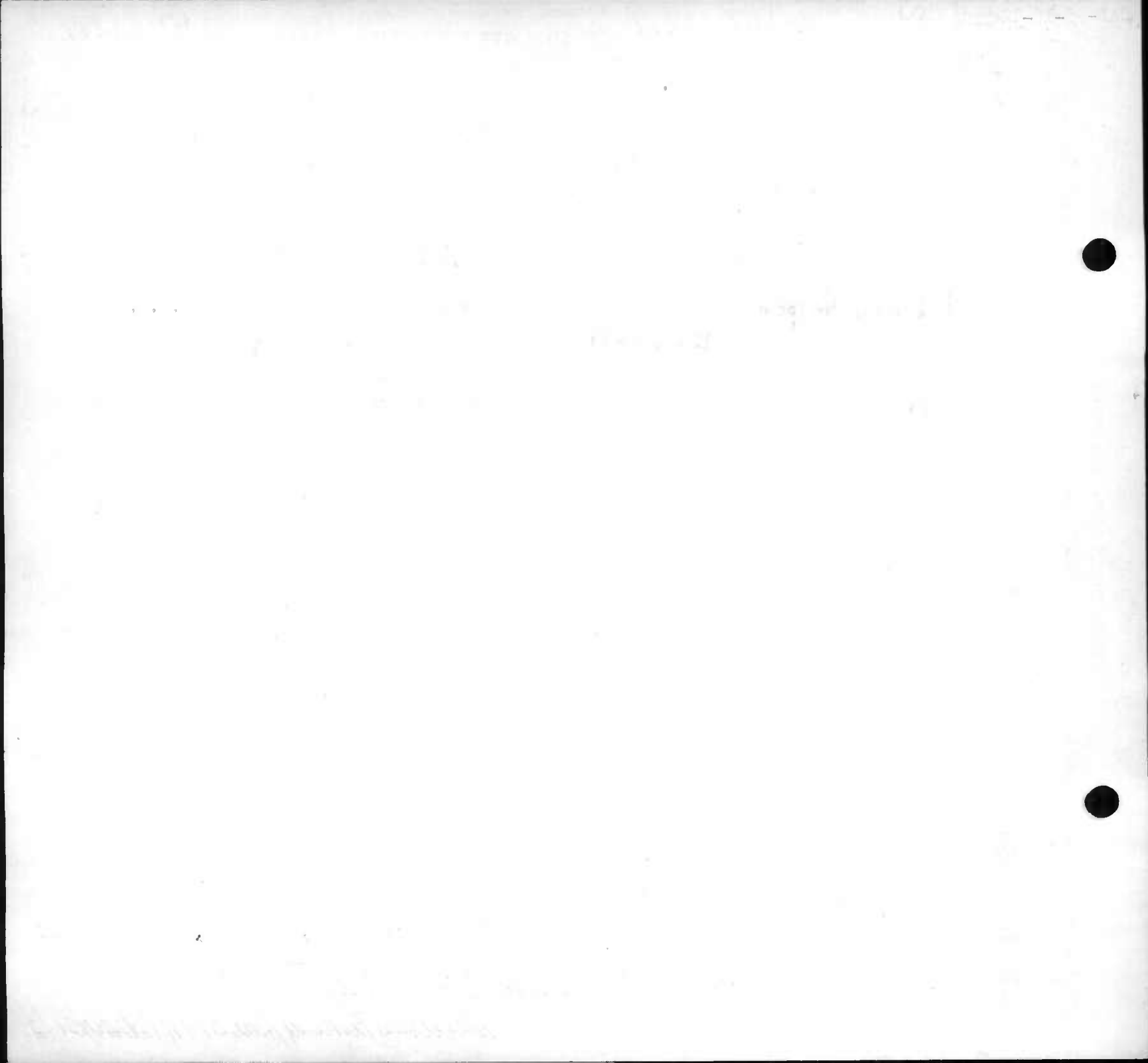
WELLY PONDGE

WELLY PONDGE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11277		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11277	
M.E. CASE NO. 35-16-22		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Garrett, Richard H.			2. DATE AND HOUR OF DEATH 11/21/67 5:55 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-08 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 749 Edgewood Street 21229		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 9/7/1940	9. AGE (In years last birthday) 27	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kitchen Helper		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Richard Garrett			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 355-X1 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Severe debility			CAUSE OF DEATH (A) olivopontine-cerebellar degeneration (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 9 years		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/22/67 to 11/21/67, that (I) (we) last saw the deceased alive on 11/21/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E.M. Levinson				23B. DATE SIGNED 11/21/67	
23C. PHYSICIAN'S NAME (Type) E.M. Levinson			23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov 25, 1967		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. Balto. Md.	
24D. LOCATION (City, town or county) (State)		25A. DATE REC'D BY HEALTH DEPT. NOV 24 1967			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Williams Funeral Home 3199 Schroeder St.			

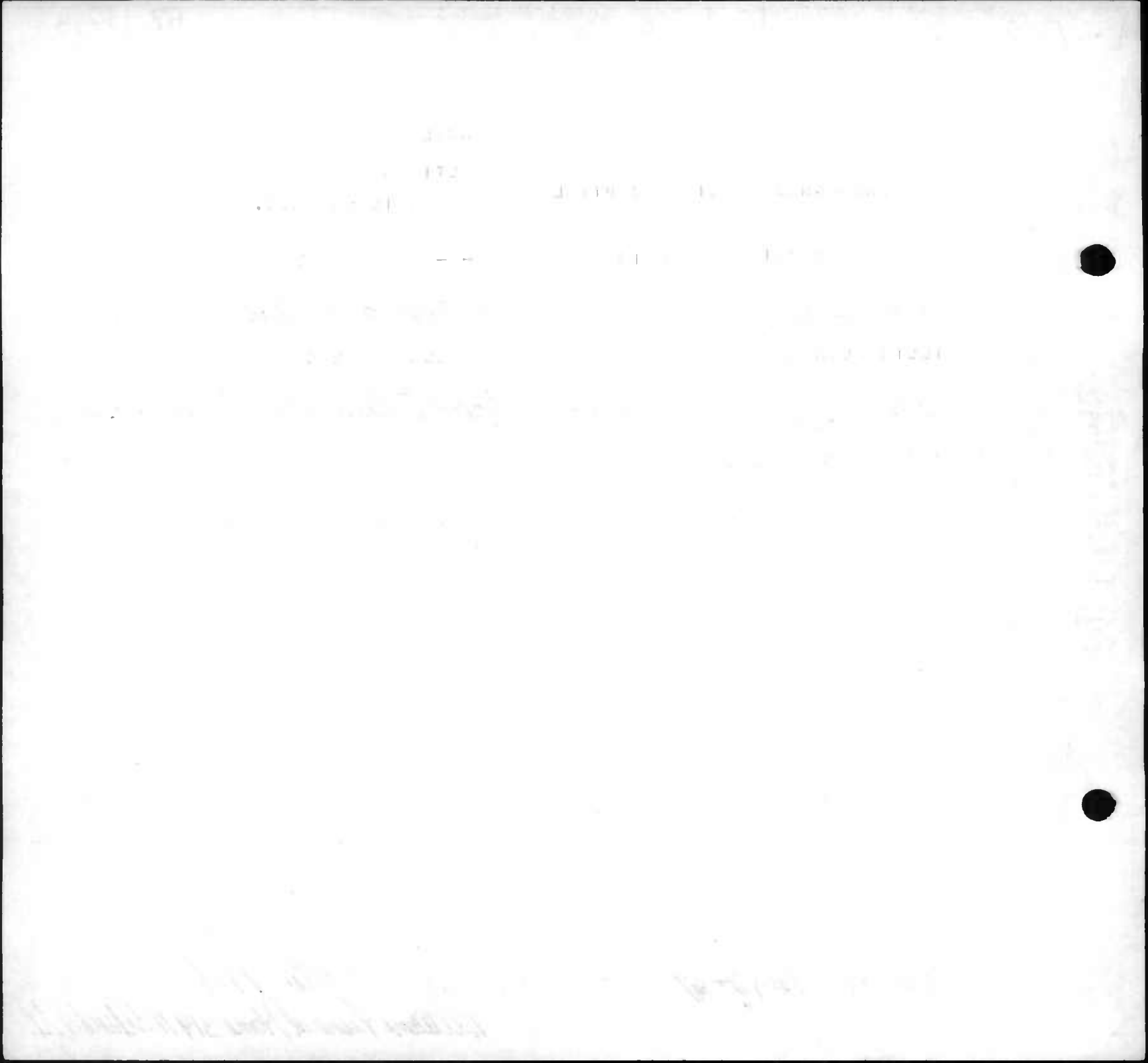




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

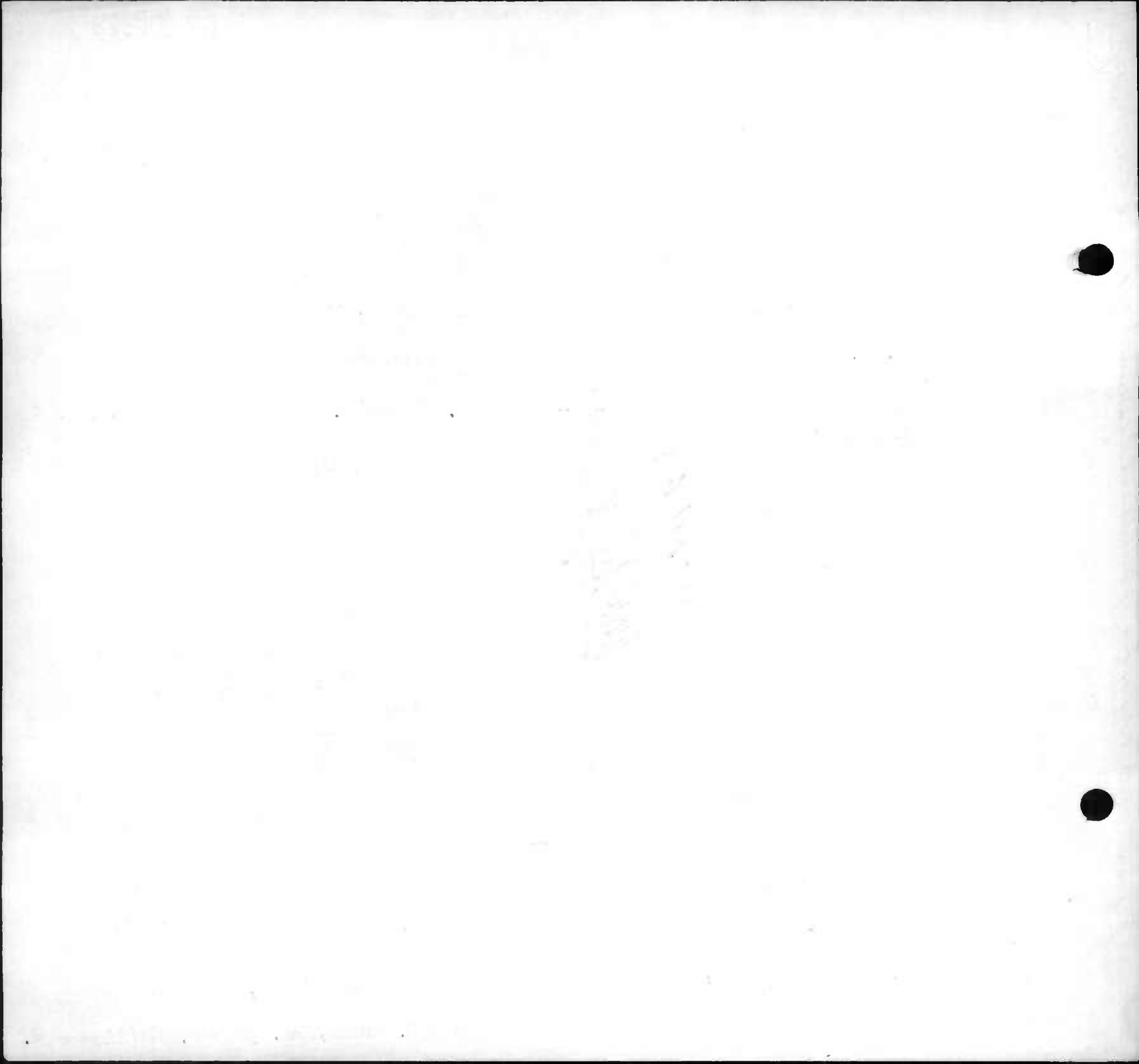
67 11278		BALTIMORE CITY HEALTH DEPARTMENT		67 11278	
BIRTH NO.		M.E. CASE NO.		Registered No.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
Juanita Davis		11-20-67 12:35 P.M.		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. SEX	
THE JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND		F	
6. RACE NEGROID		B. COUNTY BALTIMORE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	
8. DATE OF BIRTH 3-4-30		9. AGE (In years lost birthday) 37		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Youngstown Ohio		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME WILLIE PLUMMER	
14. MOTHER'S MAIDEN NAME ELLA ROSELLE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Robert Davis		ADDRESS 1802 Guilford Ave		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DUE TO Uremia		INTERVAL BETWEEN ONSET AND DEATH 1 month	
ANTECEDENT CAUSES		(B) DUE TO Hypertension		2 months	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 10-2 1967 to 11-20 1967, that (we) last saw the deceased alive on 11-20 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Russo				23B. DATE SIGNED 11-20-67	
23C. PHYSICIAN'S NAME (Type) JOHN V. RUSSO				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Nov 24 1967		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. Balt. Md.	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 24 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 319 N. Charles St.			



5231  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO. 67 11279		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11279	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Anna Yeager Engstrom		2. DATE AND HOUR OF DEATH 11/22/67 10 <sup>00</sup> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 809 Belgian Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-10 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 809 Belgian Avenue			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 12/17/1881	9. AGE (In years last birthday) 85	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME G. F. Yeager		14. MOTHER'S MAIDEN NAME Emma Schaffer	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-20-0153		17. INFORMANT Dr. Edmund G. Beecham 710 Thornwood Ct	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Mycardial Infarction		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Immediate	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from January 1967 to November 22 1967, that (I) (we) last saw the deceased alive on January 19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE A. Allan Spier		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/22/67	
23C. PHYSICIAN'S NAME (Type) A. ALLAN SPIER		23D. ADDRESS M.D. 1501 PENTRIDGE ROAD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/25/67		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park	
24D. LOCATION Baltimore, Maryland		24E. NAME OF REGISTRAR Robert E. Taylor, M.D.		24F. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St.	
25A. DATE REC'D BY HEALTH DEPT. NOV 24 1967		25B. NAME OF REGISTRAR			



M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Nelson, Mary C.

2. DATE AND HOUR OF DEATH

21 November 1967 | 5:30 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)31 Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

2322 Cambridge Street 21224

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

11-28-1885

9. AGE (In years  
last birthday)

82

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Packing House

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Cook

14. MOTHER'S MAIDEN NAME

Mary Cook

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

218-09-6233-AR records: BCH-4940 Eastern Avenue 21224

17. INFORMANT

ADDRESS

18. 492X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) RLL Pneumonitis  
DUE TO

12 da

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(B) \_\_\_\_\_  
DUE TO

(C) \_\_\_\_\_

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

ASCVD, CHF, CBS

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

While At ☐ Not While ☐  
Work At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5 OCTOBER 1967 to 21 NOVEMBER 1967.  
that (I) (we) lost saw the deceased alive on 21 NOVEMBER 1967 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Melvyn S. Tockman

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

21 November '67

23C. PHYSICIAN'S  
NAME (Type)

Melvyn S. Tockman

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

11-25-1967

24C. NAME OF CEMETERY or CREMATORY

St. Michael Ukanian

24D. LOCATION

(City, town, or county)

Baltimore County, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

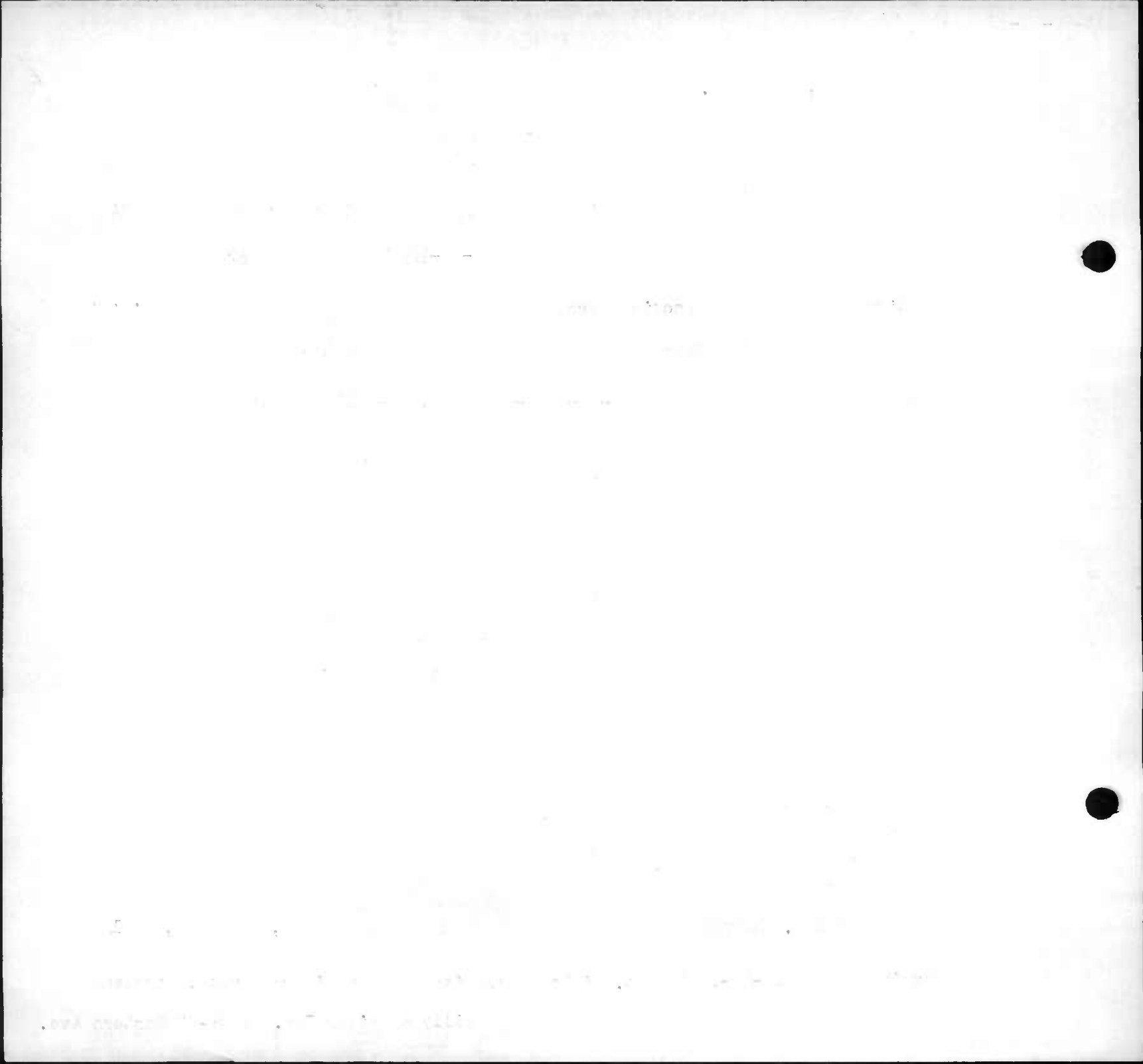
NOV 24 1967

25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>W-436</b></p> <p><b>67 11281</b></p>		<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>Registered No. <b>67 11281</b></p>	
<p>BIRTH NO. <b>W-436</b></p> <p>M.E. CASE NO.</p>		<p>1. NAME OF DECEASED (Type or Print) <b>Anna M Walters</b></p>		<p>2. DATE AND HOUR OF DEATH <b>Nov. 22, 1967</b> <b>3 30 P.</b> M.</p>	
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p><b>2915 Glendale Ave</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)</p> <p>A. STATE <b>Maryland</b></p> <p>B. COUNTY</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b></p> <p>D. STREET ADDRESS (If rural, give location) <b>2915 Glendale Ave</b></p>			
<p>5. SEX <b>Female</b></p>	<p>6. RACE <b>White</b></p>	<p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b></p>	<p>8. DATE OF BIRTH <b>Aug. 15, 1888</b></p>	<p>9. AGE (In years last birthday) <b>79</b></p>	<p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b></p>		<p>11. BIRTHPLACE (State or foreign country) <b>Maryland</b></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>					
<p>13. FATHER'S NAME <b>Michael Kelly</b></p>			<p>14. MOTHER'S MAIDEN NAME <b>Mary</b></p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>		<p>16. SOCIAL SECURITY NO. <b>173-20-2363</b></p>		<p>17. INFORMANT <b>Mrs Evelyn Becker</b> ADDRESS <b>Same</b></p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)</p> <p><b>422.11</b></p>		<p>CAUSE OF DEATH</p> <p>(A) DUE TO <b>Congestive Heart failure</b></p> <p>(B) DUE TO <b>Atherosclerotic Cardiovascular Disease</b></p> <p>(C)</p>		<p>INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
<p>19A. DATE OF OPERATION <b>0</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <b>No</b></p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>					
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>Aug 21 1967</b> to <b>Nov 24 1967</b> and that in my (aur) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <b>Frank Kasik</b></p>				<p>23B. DATE SIGNED <b>11/24/67</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>Frank Kasik</b></p>				<p>23D. ADDRESS <b>9005 Harford Rd Baltimore, Md</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>11/25/67</b></p>		<p>24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Park</b></p>	
<p>24D. LOCATION (City, town, or county) <b>Baltimore Maryland</b></p>					
<p>25A. DATE REC'D BY HEALTH DEPT. <b>NOV 24 1967</b></p>		<p>25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b></p>		<p>25C. FUNERAL DIRECTOR <b>Leonard J Ruck Inc 5305 Harford Rd</b></p>	

Corporate Board of Directors  
International Business Machines Corporation

Nov 21 1967

John H. O'Sullivan  
X



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-625		67 11282		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11282	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JAMES H. ERISMAN, JR.</b>				11-22-67 12 30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Md. General Hospital</b>				A. STATE <b>MD</b>			
(If not in hospital or institution, give street address or location)				B. COUNTY <b>BALTO MD</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO MD</b>			
				D. STREET ADDRESS (If usual, give location) <b>53-00</b>			
5. SEX <b>Male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>1-15-12</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN HEATER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>STEEL CO.</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES H. ERISMAN</b>				14. MOTHER'S MAIDEN NAME <b>ELIZ. WINTH</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-09-1605</b>		17. INFORMANT <b>MRS. RUBY M. ERISMAN (SAME)</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ASPIRATION OF REGURGITATED BLOOD</b> DUE TO <b>HEMORRAGE from ESOPHAGEAL VARICES</b> DUE TO <b>PORTAL CIRCULOSIS</b> DUE TO <b>ACUTE CHRONIC</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Minutes</b> <b>4 years</b> <b>4 yrs</b>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 11-22 1967, that (I) (we) last saw the deceased alive on 11-22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Fredrik Bjornsson M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-22 67</b>	
23C. PHYSICIAN'S NAME (Type) <b>F. BJORNSSON</b>				23D. ADDRESS <b>Maryland General</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/27/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>PARKWOOD CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 24 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>LEONARD J. RUCK, INC.</b>		ADDRESS <b>21214</b>	

JAMES H. EDWARDS

1000 F. Road 1200 A-2

DATE 1/12

1-12-12 22

Mole marks

USA

Boyle

Unknown

812 W. 12th

JAMES H. EDWARDS

212-04-002

1/12

1/12-04-002

1/12

1/12-04-002

1/12-04-002

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-535		67 11283		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11283	
M.E. CASE NO.				BIRTH NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
William ELVERTA HIXTON				Nov. 21, 1967 6:35 P.M.		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	
44 Union Memorial Hosp.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
MARYLAND				BALTIMORE		D. STREET ADDRESS (If rural, give location)	
800 MELVILLE AVE				9-03		5. SEX	
F		6. RACE		W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
Widow		8. DATE OF BIRTH		11/1/10		9. AGE (In years last birthday)	
67		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Housewife		Maryland		12. CITIZEN OF WHAT COUNTRY?	
U.S.		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
no		Charles Wilhelm		Mary Katherine Stone		16. SOCIAL SECURITY NO.	
220-50-2361		17. INFORMANT		ADDRESS		18. CAUSE OF DEATH	
Mrs. Mildred Larkins 3218 Orlando Ave. 34		Interval Between Onset and Death		(A) Generalized Atherosclerosis		(B) Cerebral Vascular Accident	
(C)		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		ANTECEDENT CAUSES		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
No		No		No		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		22. I certify that (this hospital) attended the deceased from 11/14 1967 to 11/21 1967		that (I) last saw the deceased alive on 11/21 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
W. H. Oehlert Jr.		11/21/67		DR. WILLIAM H. OEHLERT, JR.		THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		11/25/67		Moreland Park Cem.		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 24 1967		Robert E. Fairbank		Leonard J. Ruck Inc.		Balto. Md.	

~~\_\_\_\_\_~~

72 01/14

04/04/2014

Katherine  
25-2

Thompson, Charles

Charles Francis Adams

4

10/15/94

20/04

W. H. Abbott

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

George Miller

Marland

Galt

4202 White Ave

2/11/82

M W

George Miller

George Miller

4202 White

Marland

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>D-100</b>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 11285</b>	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Harold Luther Doub</b>				2. DATE AND HOUR OF DEATH <b>Nov. 23, 1967. 10 A. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1817 Woodbourne Ave.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1817 Woodbourne Ave</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>7/20/11</b>	9. AGE (In years last birthday) <b>56 5/4</b>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mutual Seller</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Md. Racing Comm.</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Oscar Doub</b>				
14. MOTHER'S MAIDEN NAME <b>Unknown</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				
16. SOCIAL SECURITY NO. <b>163-03-5842</b>			17. INFORMANT ADDRESS <b>Mrs May Doub Same</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) <b>420.21</b> <b>Hypertensive arteriosclerosis with angina pectoris</b>				CAUSE OF DEATH <b>END with angina pectoris</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 1/2 yrs.</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Nat While <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>Feb. 1961</b> to <b>Nov. 1967</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>10/4</b> 19 <b>67</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.							
23A. SIGNATURE <b>Wm. H. Kammer Jr.</b>				23B. DATE SIGNED <b>24 Nov. 1967</b>			
23C. PHYSICIAN'S NAME (Type) <b>William H Kammer Jr</b>				23D. ADDRESS <b>6011 York Rd Baltimore, Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/27/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 24 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J Ruck Inc 5305 Harford Rd</b>			

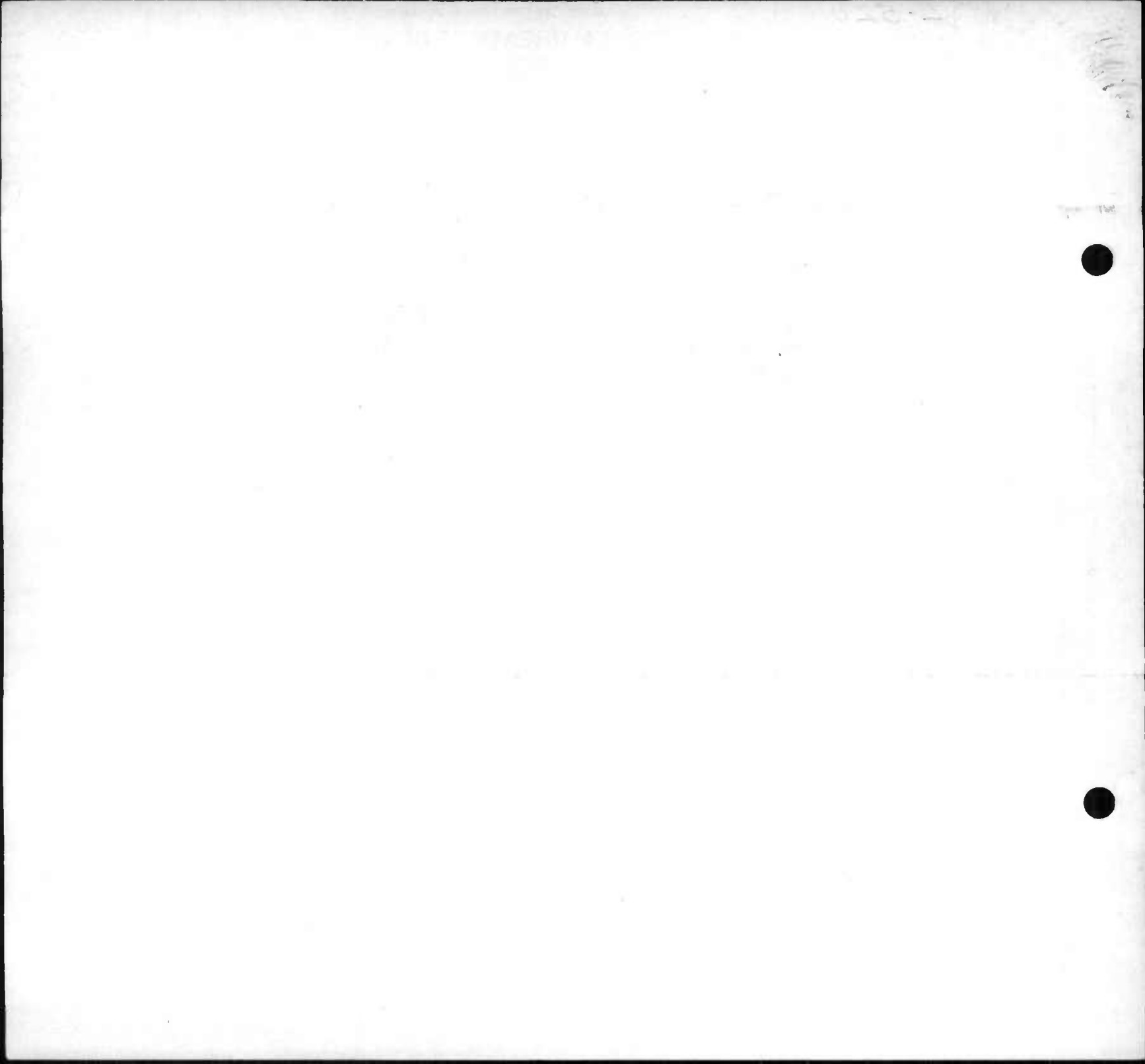




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

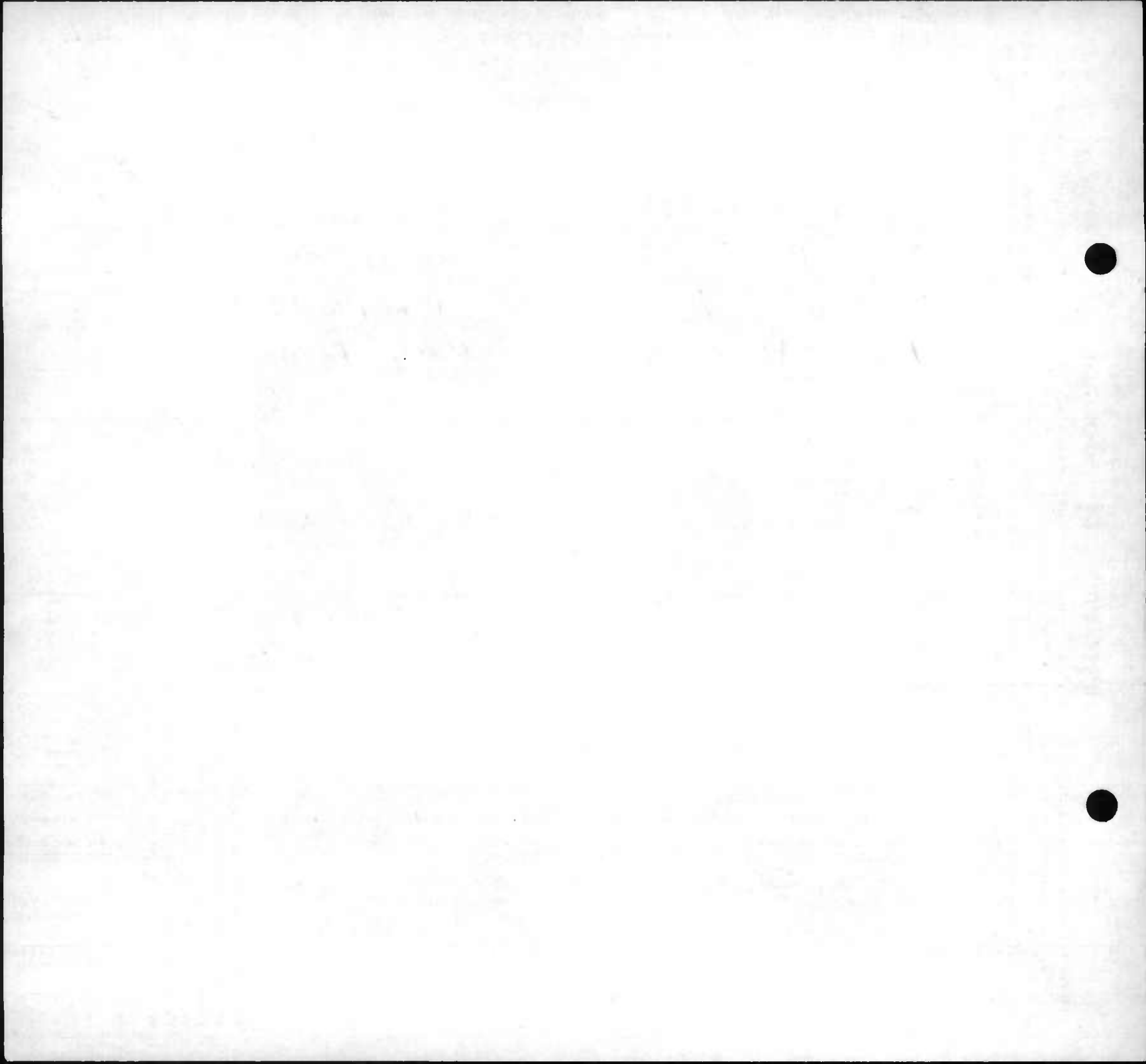
Z-520		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11286	
BIRTH NO. 67 11286		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SOPHIA P. ZINK		November 21, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  00 4504 Harford Road			A. STATE Maryland		
			B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore 21214		
			D. STREET ADDRESS (If rural, give location)		
			4504 Harford road		
5. SEX F.	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH May 28, 1878	9. AGE (in years last birthday) 89	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
			Baltimore, Maryland		USA
13. FATHER'S NAME William C. Weaver			14. MOTHER'S MAIDEN NAME Minnie Seibel		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mr EDwin C. Weaver 702 Winans Way 212		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 420.01		CAUSE OF DEATH (A) DUE TO Arterio sclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 29 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO			
		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/18/67 1945 to 11/21 1967, that (I) (we) last saw the deceased alive on 11/18/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Walter E. Karfgin M.D.				23B. DATE SIGNED 11/22/67	
23C. PHYSICIAN'S NAME (Type) Walter Karfgin M.D.				23D. ADDRESS 4331 Harford Road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/24/67		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 24 1967		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS INC. BALTIMORE MARYLAND	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>P-620</b>      <b>67 11287</b></p> <p style="font-size: 1.2em;">BIRTH NO.</p>		<p><b>CERTIFICATE OF DEATH</b></p> <p style="font-size: 1.2em;">Registered No. <b>67 11287</b></p>	
<p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <b>Roy Price</b></p>		<p>2. DATE AND HOUR OF DEATH <b>11-15-67</b>      <b>6:45</b> A.M.</p>	
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>37 Mercy Hospital</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>3225 Leveeton Ave.</b></p>	
<p>5. SEX <b>m</b></p>	<p>6. RACE <b>w</b></p>	<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b></p>	<p>8. DATE OF BIRTH <b>10-19-1894</b></p>
<p>9. AGE (In years, last birthday) <b>73</b></p>		<p>10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b></p>	<p>10. B. KIND OF BUSINESS OR INDUSTRY <b>POLICEMAN</b></p>
<p>11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>	
<p>13. FATHER'S NAME <b>Norris Price</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Mary Frances Myers</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWII</b></p>		<p>16. SOCIAL SECURITY NO.</p>	<p>17. INFORMANT ADDRESS <b>Miss Angeline Price 3202 Fleet St.</b></p>
<p>18. <b>42011</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH (A) <b>Acute MI? Extension of CVA?</b> DUE TO (B) <b>Cardiovascular Disease</b> DUE TO (C)</p>	
<p>INTERVAL BETWEEN ONSET AND DEATH</p>			
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <b>NO</b></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>October 25 1967</b> to <b>November 15 1967</b>, that (I) (we) last saw the deceased alive on <b>November 15 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>Bayan L. Manalo</b> M.D.</p>		<p>23B. DATE SIGNED <b>11-15-67</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>BAYAN L. MANALO</b></p>		<p>23D. ADDRESS <b>Mercy Hospital, Balto. Md. 21202</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b></p>		<p>24B. DATE <b>11-18-67</b></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEMORIAL</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>NOV 24 1967</b></p>		<p>25B. NAME OF REGISTRAR <b>Robert E. Taylor</b></p>	
<p>25C. FUNERAL DIRECTOR <b>RAYMOND L. KACZOROWSKI</b></p>		<p>ADDRESS <b>2525 FLEET ST.</b></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-256 67 11288		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 67 11288	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				MATT Hew M. WAGNER	
2. DATE AND HOUR OF DEATH		11-16-67 7:30 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE B. COUNTY			
2518 FAIT Ave		Md. C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
00		Baltimore 1-03			
D. STREET ADDRESS (If rural, give location)		SAME 2518 Fait Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
M	W		2-19-04	63	Self-emp. Produce
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Produce		MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Michael WAGNER			Elizabeth HANSEN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NCO		216-31-6965		Helen WAGNER SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) Brain Tumor - Left Temporal		5 mo.	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
		Hypertensive Cardio-vascular Disease 10 Yrs.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from December 19 54 to November 1967, that (I) (we) last saw the deceased alive on November 11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Clarence W. LeDoux M.D.				11/17/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Clarence W. LeDoux		3023 Eastern Ave. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		11-20-67		SACRED Heart	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 24 1967		Robert E. Taylor		Raymond L. Kaczorowski	
				2525 Fleet St	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11289		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11289	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BEATRICE B. EPPES (Betty)		2. DATE AND HOUR OF DEATH 11-23-67 9 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MARYLAND 730 ASHBURTON ST. BALTIMORE MD. 21216		D. STREET ADDRESS (If rural, give location) 519-N STRICKER ST.		19-01	
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 3-28-08	9. AGE (In years last birthday) 59	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Northway Co., VA	
13. FATHER'S NAME Wyatt Archer		14. MOTHER'S MAIDEN NAME Tannie Archer		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Louis HARPER 519 Stricker	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DIABETES MELLITUS (B) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE (C) HYPERTENSION		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. OBESITY					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-20-67 1967 to 11-23 1967, that (I) (we) last saw the deceased alive on 11-23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Aziz		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11-23-67	
23C. PHYSICIAN'S NAME (Type) S. AZIZ		23D. ADDRESS M.D. 730 ASHBURTON ST. BALTIMORE, MD. 21216			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-28-67		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION Arbutus, Maryland		24E. NAME OF CEMETERY or CREMATORY Arbutus		24F. LOCATION Arbutus, Maryland	
25A. DATE RECEIVED BY HEALTH DEPT. NOV 24 1967		25B. NAME OF REGISTRAR Robert E. Jones		25C. FUNERAL DIRECTOR Horton E. Dyett F.H. 1701 Luarens	

934



R-263

67 11290

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11290

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CARNELL RICHARDS

2. DATE AND HOUR PRONOUNCED DEAD

November 21, 1967 5:28 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2135 W. Baltimore St.

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

11-2-1940

9. AGE (in years last birthday)

27

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

COLUMBUS RICHARDS

14. MOTHER'S MAIDEN NAME

LILLIAN STEWART

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Lillian Richards 2135 W. Balto. St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A)

Gunshot wound of the head with laceration of the brain

~~XXXXXX~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street ( House)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

765 W. Pratt Street

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) 11 21 67 3:05

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Subject found of floor, subject was shot

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion

resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Edward F. Wilson, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

11-25-67

23C. NAME of CEMETERY or CREMATORY

Mount Zion Cemetery

23D. LOCATION

Magothy,

Maryland

24A. DATE REC'D BY HEALTH DEPT.

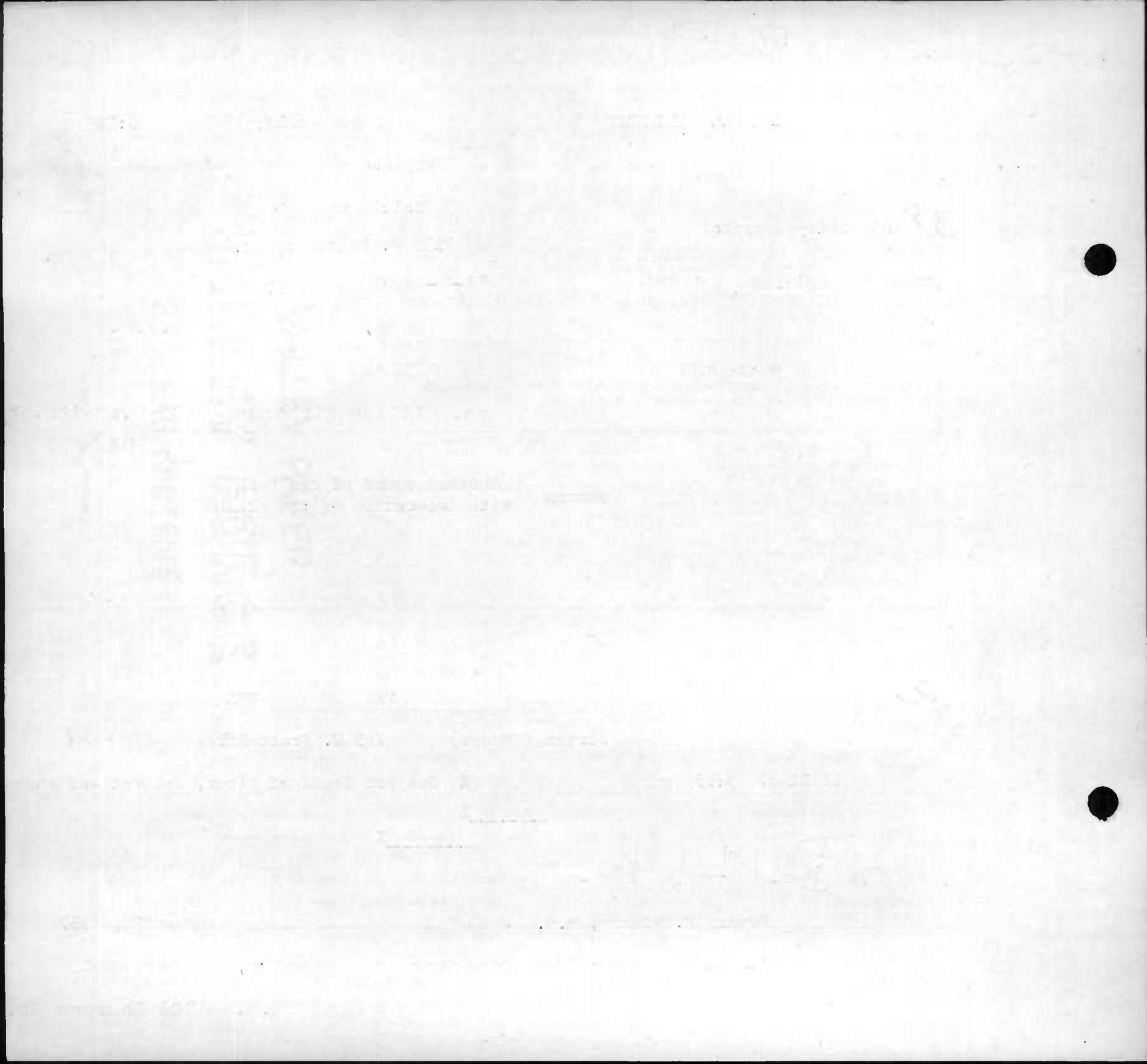
NOV 24 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.


24C. FUNERAL DIRECTOR

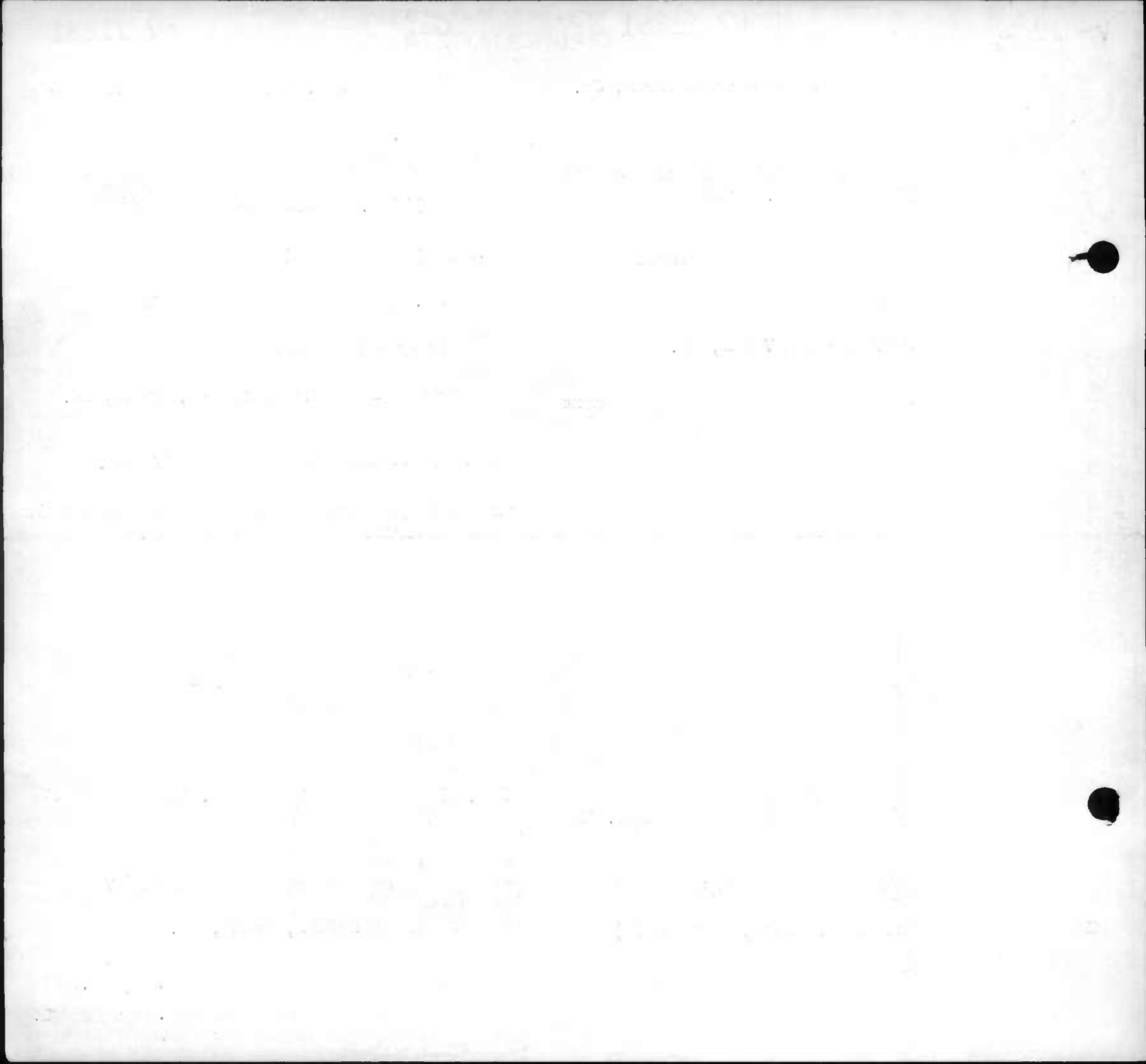
MORTON & DYETT F.H. 1701 Laurens St.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <b>67 11291</b>	
CERTIFICATE OF DEATH											
BIRTH NO. <b>64-28526 67 11291</b>											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) <b>John Carlton Virts, Jr.</b>					2. DATE AND HOUR OF DEATH <b>Nov. 21, 1967 2:55 A.M.</b>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY						
FULL NAME OF HOSPITAL OR INSTITUTION <b>US Public Health Service Hospital</b> <b>3100 Wyman Pk. Drive</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>						
					D. STREET ADDRESS (If rural, give location) <b>329 S. Payson Street</b>						
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>			8. DATE OF BIRTH <b>9/18/63</b>	9. AGE (In years last birthday) <b>4</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John Carlton Virts, Sr.</b>					14. MOTHER'S MAIDEN NAME <b>Margaret Waldner</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>					16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Records- US PHS Hospital, Balto, Md.</b>				
18. <b>299X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary hemorrhage</b> (A) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>						
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Suspected myeloproliferative disorder</b> (B) DUE TO					Several months						
(C)											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <b>2</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <b>Nov. 13</b> 19 <b>67</b> to <b>Nov. 21</b> 19 <b>67</b> , that (1) (we) last saw the deceased alive on <b>Nov. 21</b> 19 <b>67</b> and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.											
23A. SIGNATURE  Walter F. Oster, Surgeon (R)								M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/21/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Walter F. Oster, Surgeon (R)</b>					23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>						
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>11/22/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Old Frederick Rd. Balto. Md</b>			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>			25C. FUNERAL DIRECTOR ADDRESS <b>KRAUSE FUNERAL HOME 1216 S. Charles St.</b>					



T-500

67 11292

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

67 11292

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

NICHOLAS L. Tana

~~XXXXXX~~

2. DATE AND HOUR PRONOUNCED DEAD

November 25, 1967

5:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

St. Agnes Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

~~XXXXXXXXXX~~

Lansdowne

D. STREET ADDRESS (If rural, give location)

3064 Bero Rd.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

11-4-1925

9. AGE (In years  
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Machine Operator

10B. KIND OF BUSINESS OR INDUSTRY

Inland Steel Prods.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Michael Tana

14. MOTHER'S MAIDEN NAME

Louisa Berno

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

217-18-0141

17. INFORMANT

ADDRESS

Mrs. Jeanette M. Tana, 3064 Bero Road 21227

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A)  
DUE TO

Arteriosclerotic heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-25-67

EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11-28-1967

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

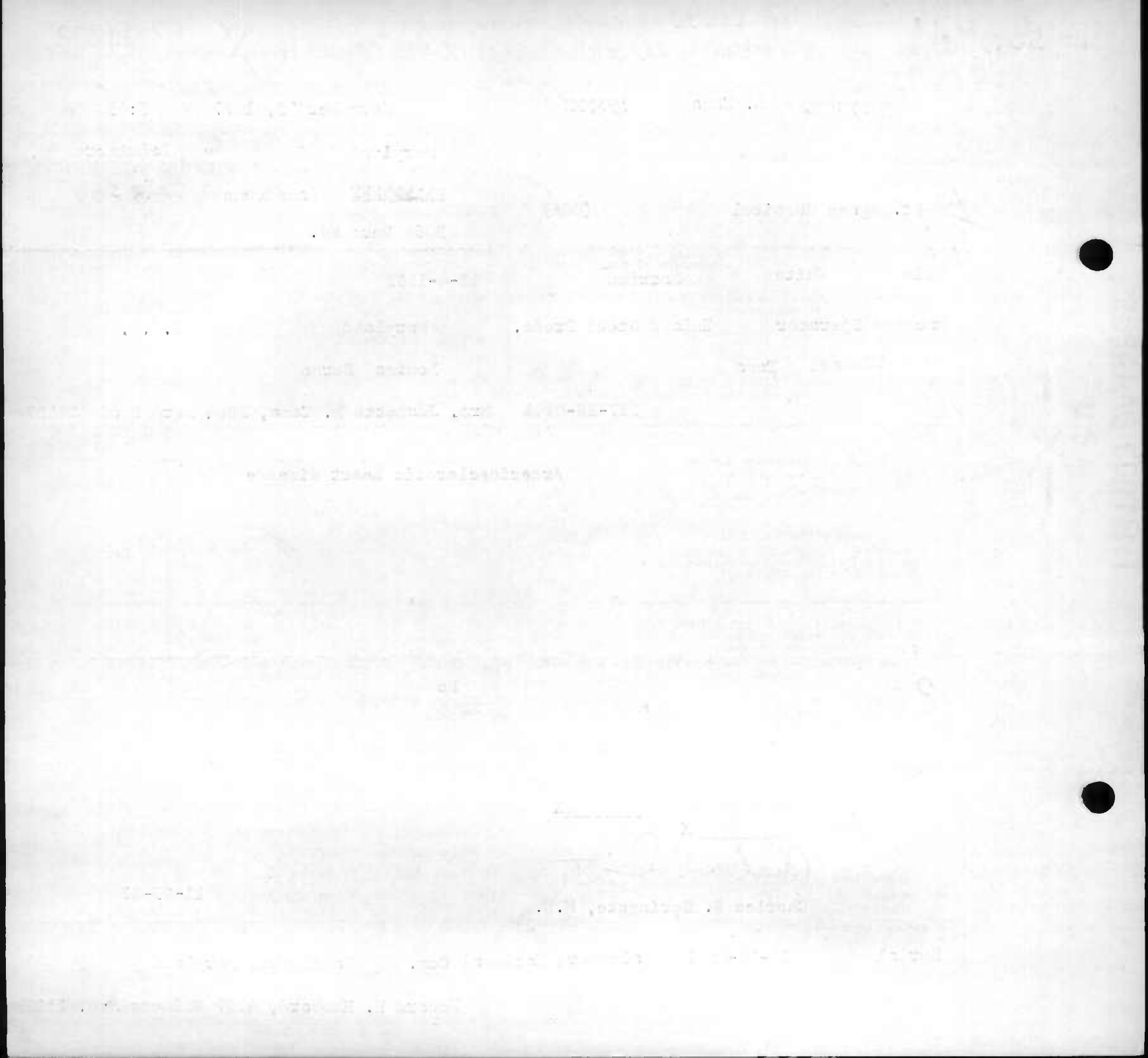
24C. FUNERAL DIRECTOR

ADDRESS

NOV 27 1967

Robert E. Fairbank

Howard H. Hubbard, 4107 Wilkens Ave. 21229



C-516

67 11293 BALTIMORE CITY HEALTH DEPARTMENT

67 11293

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

PERCY W. CHAMBERS

2. DATE AND HOUR PRONOUNCED DEAD

November 25, 1967 2:50 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

305 Millington Lane

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

MAY 2, 1893

9. AGE (In years  
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

CEMETERY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George W. Chambers

14. MOTHER'S MAIDEN NAME

ELLA JAMIR

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES WORLD WAR I

16. SOCIAL  
SECURITY NO.

419-02-0838

17. INFORMANT

NANNIE Chambers 305 MILLINGTON AVE

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TOANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)  
(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 26, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

BURIAL

11-29-67

BALTIMORE, NATIONAL

BALTIMORE, MD

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

NOV 27 1967

Robert E. Fairbank

Geo. L. Schwab Funeral Home  
Francis H. Miller 2101 Frederick Ave

George W. Chambers  
Conventry  
May 2, 1893

Yes world war I was the worst

During 1914-17, Eastern Europe, Eastern Asia  
and the Middle East were the most



W-106 1

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

67 11294 CERTIFICATE OF DEATH

Registered No.

67 11294

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WEBB, MARY M.

2. DATE AND HOUR OF DEATH

11/24/67

9:30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

LANDSOWNE

21227

D. STREET ADDRESS (If rural, give location)

2404 SARATOGA AVENUE

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

09/06/85

9. AGE (In years  
last birthday)

82

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

Domestic

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ALLEN WILSON

14. MOTHER'S MAIDEN NAME

AGNES DORSEY

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

NONE

16. SOCIAL  
SECURITY NO.

NONE

17. INFORMANT

ADDRESS

ST AGNES RECORDS-CATON &amp; WILKENS AVES.

18. 434.41260X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) PULMONARY EDEMA, ACUTE

DAYS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(B) HYPERTROPHY & DILATATION  
OF THE HEART

YEARS

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

DIABETES MELLITUS

YEARS.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
WorkNot While  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 23, 1967 to NOVEMBER 24, 1967,  
that (I) (we) lost saw the deceased alive on NOVEMBER 24, 1967 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Michael E. Pelczar

M.D.

Attending  
Phys.Med.  
DirectorStaff  
Phys.

23B. DATE SIGNED

11/24/67

23C. PHYSICIAN'S  
NAME (Type)

DR. MICHAEL E. PELCZAR

M.D.

23D. ADDRESS

CATON &amp; WILKENS AVES., BALTO., MD.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

11-28-67

24C. NAME OF CEMETERY or CREMATORY

MT. OLIVET

24D. LOCATION

(City, town, or county)

BALTIMORE, MD

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 27 1967

25B. NAME OF REGISTRAR

Robert E. Fisher, MA

25C. FUNERAL DIRECTOR

Francis H. Spiller 2101 Thelwell Ave

DATE: 10-10-68

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

DATE: 10-10-68

BY: [illegible]

ST. LOUIS, MO. 10-10-68

NY 100-100000

NY 100-100000

[illegible handwritten notes]

YES

NOVEMBER 1, 1968

[illegible handwritten notes and signatures]

M-4601

67 11295

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

67 11295

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HELEN I. MILLER

2. DATE AND HOUR OF DEATH

11/24/67

15:00 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street  
address or location)

33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)  
BALTIMORE

D. STREET ADDRESS (If rural, give location)

1931 WIDKENS AVENUE

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

WIDOW

8. DATE OF BIRTH

7-9-99

9. AGE (In years  
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

SEAMSTRESS

10B. KIND OF BUSINESS OR INDUSTRY

Clothing Mfg.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

GEORGE W. O'NEALE

14. MOTHER'S MAIDEN NAME

MARY ROYING

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

NONE

16. SOCIAL  
SECURITY NO.

220-18-8613

17. INFORMANT

ARLEYNE MILLER 1931 WIDKENS AVE

ADDRESS

18. 434 JX 018.2  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Congestive Heart Failure

(B) DUE TO

ASCVD or RAD

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

3 months

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

? the pericarditis

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

NO

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/13 1967 to 11/24 1967,  
that (I) (we) last saw the deceased alive on 11/24 1967 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Henry R. Black

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

11/24/67

23C. PHYSICIAN'S  
NAME (Type)

HENRY R. BLACK

M.D.

23D. ADDRESS

Johns Hopkins Hosp

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

11-27-67

24C. NAME OF CEMETERY OR CREMATORY

WESTERN

24D. LOCATION

(City, town, or county)

BALTIMORE, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 27 1967

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Geo. L. Schwalb Funeral Home  
Francis H. Miller 2101 Frederick Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

4-24

Handland  
May 1919

Severance (Clerk of)

Severance (Clerk of) 1919

4-24

4-24

Severance (Clerk of)  
1919

Severance (Clerk of)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11296		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11296	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <i>Charles E. James</i>		2. DATE AND HOUR OF DEATH <i>Nov 26/1967</i> <i>1:00 P</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>H2 SINAI</i>		A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (All outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>1917 McHenry Street</i>			
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>12/28/194</i>	9. AGE (In years last birthday) <i>22</i>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Freight Conductor</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>RAILROAD</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>WILLIAM JAMES</i>		14. MOTHER'S MAIDEN NAME <i>MARY RAY</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>717-07-8395</i>		17. INFORMANT <i>NOPE JAMES 1917 McHENRY ST.</i>	
18. <i>600.0 I</i>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Congestive Heart Failure</i> DUE TO <i>azotemia with anemia</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Chronic pyelonephritis</i> DUE TO <i>many years</i>			
		(C) <i>Chronic pyelonephritis</i>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Nov 24</i> 19 <i>67</i> to <i>Nov 26</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Nov 26</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Richard J. Barr</i>				23B. DATE SIGNED <i>Nov. 26, 1967</i>	
23C. PHYSICIAN'S NAME (Type) <i>SINAI HOSPITAL</i>				23D. ADDRESS <i>SINAI HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>11-29-67</i>		24C. NAME of CEMETERY or CREMATORY <i>MORELAND</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTO. County Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 27 1967</i>			
25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR <i>GEO. L. Schwab FUNERAL HOME</i> <i>Francis H. Miller 2101 Frederick Ave.</i>			

10. 10. 1914

2. 10. 1914

White White  
White White

White White  
White White

White White  
White White

2. 10. 1914

White White  
White White  
White White  
White White

50-60-99 1  
IW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-530		67 11297		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11297	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO. ROSE J. SMITH				2. DATE AND HOUR OF DEATH 11/23/67 12:05 P. M.			
1. NAME OF DECEASED (Type or Print) ROSE J. SMITH				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224				BALTIMORE DUNDALK 53-00			
D. STREET ADDRESS (If rural, give location)				2426 KEYWAY - 21222			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9/24/88	9. AGE (In years lost birthday) 79	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. BIRTHPLACE (State or foreign country) GERMANY	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME JOSEPH				14. MOTHER'S MAIDEN NAME ANNA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				17. INFORMANT RECORDS: Baltimore City Hospital			
16. SOCIAL SECURITY NO. 174-03-1530				4940 Eastern Avenue, Balto. Md. 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) M. I.		~ 5 min	
ANTECEDENT CAUSES				(B) ARTERIOSCLEROSIS		years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) D. M.		years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/19 19 67 to 11/23 19 67, that (I) (we) last saw the deceased alive on 11/23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE PAUL E. MICHELSON M.D.				23B. DATE SIGNED 11/23/67		23C. PHYSICIAN'S NAME (Type) PAUL E. MICHELSON	
23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Balto. Md. 21224				23E. FUNERAL DIRECTOR W. BROOKS BRADLEY, DUNDALK, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/27/67		24C. NAME OF CEMETERY or CREMATORY ST. STANISLAUS		24D. LOCATION (City, town, or county) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. NOV 27 1967		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR W. BROOKS BRADLEY, DUNDALK, MD.			

M. E.

Microscopic

D. M.

NO

11/18/11

11/18/11

X

11/18/11



1  
C-652

67 11298 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11298

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM CARRINGTON

2. DATE AND HOUR PRONOUNCED DEAD

November 21, 1967 5:00 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4227 Rokeby Road

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Steel Worker

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alexander Carrington

14. MOTHER'S MAIDEN NAME

Bell Pullman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

213-09-0945

17. INFORMANT

ADDRESS

Frances E. Carrington 4227 Rokeby Rd

18. 260X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular  
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Diabetes  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

1 Month 1 Day 1 Year 1 Hour

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK NOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion

resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATURE

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

November 22, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

BBurial

11/25/67

Arbutus Mem. Park Cem.

Arbutus Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

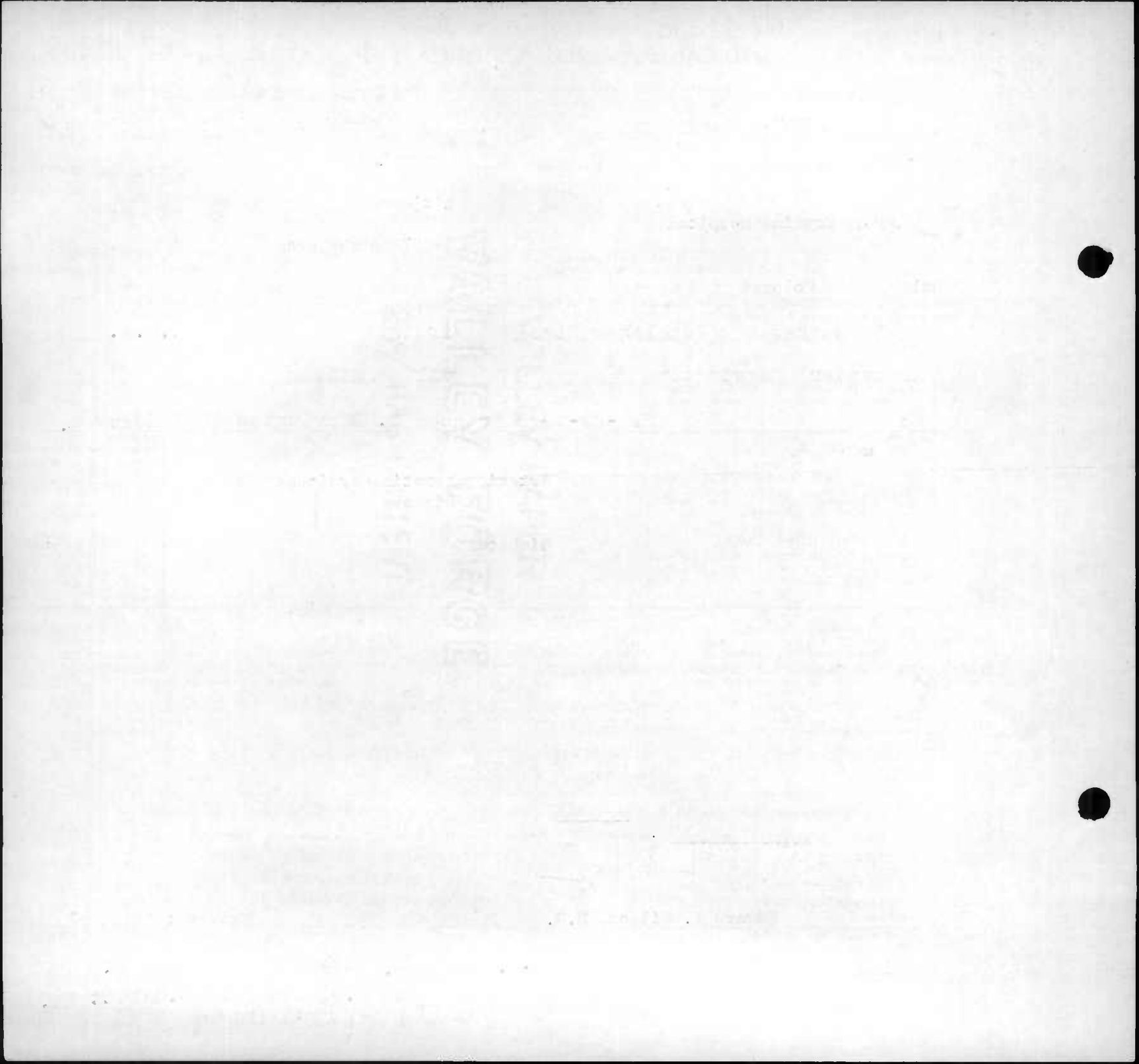
ADDRESS

NOV 27 1967

Robert E. Farley

Stetson D. Wilson 1913 W. Baltos St.

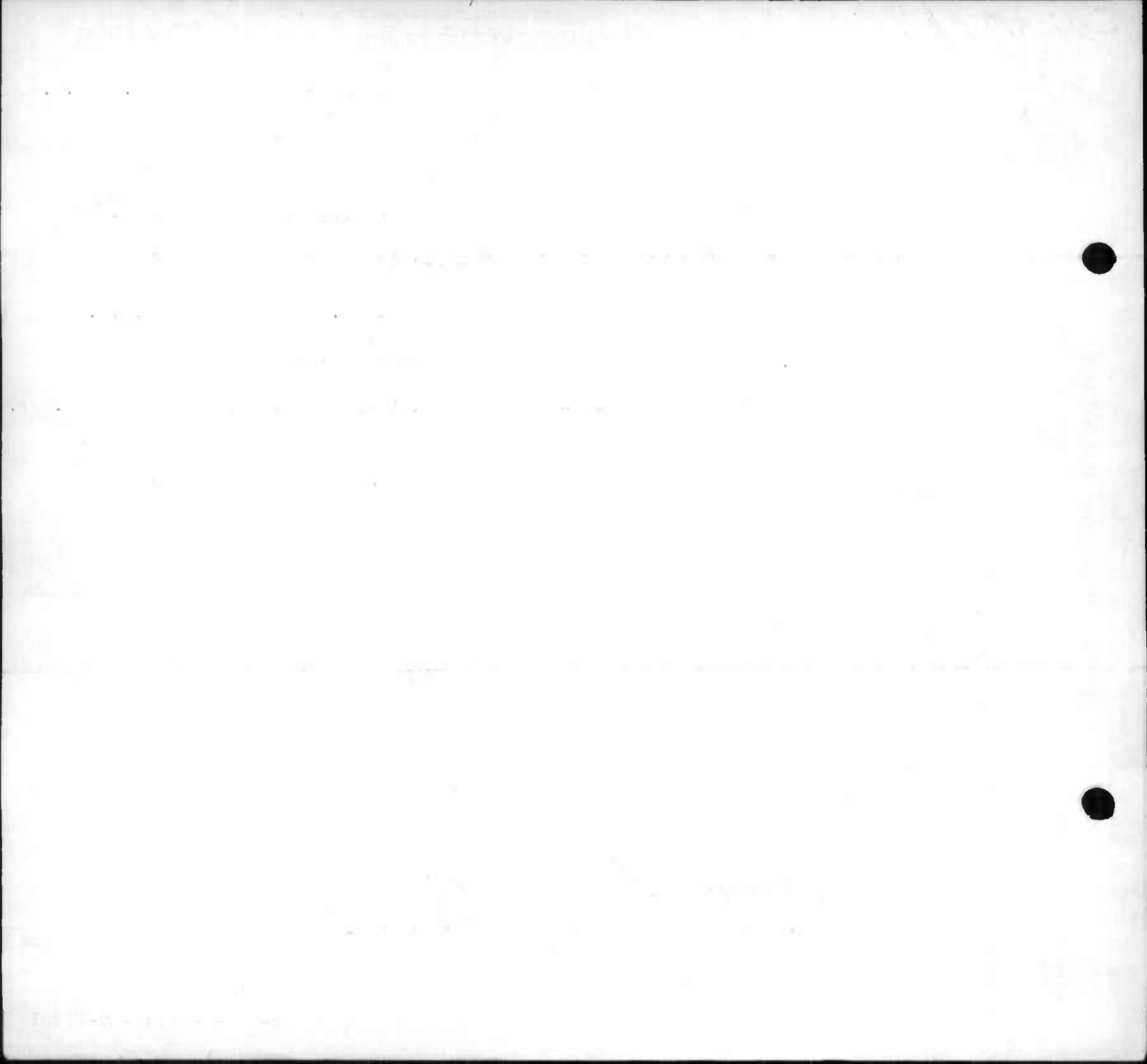
Stetson D. Wilson



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 11299</b>	
67 11299		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
M.E. CASE NO.		Nov-21-1967 8.55 A.M. M.	
1. NAME OF DECEASED (Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
MARY ELIZABETH COLE		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)	
(died at her residence)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY	
00		Maryland (Baltimore City)	
00		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
00		Baltimore 12-02	
00		D. STREET ADDRESS (If rural, give location)	
00		3415 Guilford Terrace (21218)	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
Female	White	Widow	Aug-23-1874
9. AGE (In years last birthday)		10. CITIZEN OF WHAT COUNTRY?	
93		U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
none		Baltimore, Md.	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
none		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
George W. Evans		Charlotte Cowan	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
no		218-54-3769T	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		17. INFORMANT ADDRESS	
no		Miss E.W.Cole daughter, 3415 Guilford.Ter.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
420.1 I		Myocardial Infarction	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		immediate	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		2 yrs.	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		NO	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11/21/67 to Nov 21 1967, that (I) (we) last saw the deceased alive on Nov 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
Francis W. Gluck M.D.		11/22/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Francis W. Gluck M.D.		100 W University Pkwy	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
burial		Nov-24-67	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Loudon Park		Baltimore 21229	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
NOV 27 1967		Philip E. Farkema	
25C. FUNERAL DIRECTOR ADDRESS		25D. FUNERAL DIRECTOR ADDRESS	
Stewart & Mowen Co-108-W-North-Av-21201			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11300				BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH				Registered No. 67 11300			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>KIRK PATRICK, BERTHA</b>				2. DATE AND HOUR OF DEATH <b>11/22/67 3:00 P.</b>				M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				A. STATE				B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				5. SEX <b>Female</b>				6. RACE <b>White</b>				7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>			
33 The Johns Hopkins Hospital 601 North Broadway Baltimore, Maryland 21205				MARYLAND - Baltimore				C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)			
				2513 W. Woodwell Road											
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Housewife								Virginia				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
Jones, George				Shipp, Mimmie				No				212-26-5306			
17. INFORMANT (Husband)				18. CAUSE OF DEATH				19. MEDICAL EXAMINER'S SIGNATURE				INTERVAL BETWEEN ONSET AND DEATH			
Mr. James E. Kirkpatrick, 2513 W. Woodwell Rd.				Heart Failure				M.D. [Signature]							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) DUE TO				(B) DUE TO				(C) DUE TO			
(This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				stability to come off				Cardiopulm. bypass				used for operation on RHEUMATIC HEART VALVES			
ANTECEDENT CAUSES				DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT.															
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
11/22/67				AS, AT, MS, MT				Yes							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?							
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>											
22. I certify that (I) (this hospital) attended the deceased from 11/13 1967 to 11/22 1967, that (I) (we) last saw the deceased alive on 11/22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE				23B. DATE SIGNED				23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Richard N. Scott				11/22/67				RICHARD N. SCOTT				The Johns Hopkins Hosp. Balt. Md.			
24A. BURIAL, CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY OR CREMATORY				24D. LOCATION (City, town, or county) (State)			
Burial				11/25/67				Bel Air Memorial Gardens Cem.				Bel Air, Maryland			
25A. DATE RECD. BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR				ADDRESS			
NOV 21 1967				Robert E. Fisher, M.D.				John J. Duda, 7922 Wise Ave. Dundalk, Md.							

Handwritten notes at the top of the page, including "12/11/11" and "12/11/11".

Heart Failure  
amblyopia to come off  
cardiac - problem. happen

yes 11/11/11 11/11/11 11/11/11

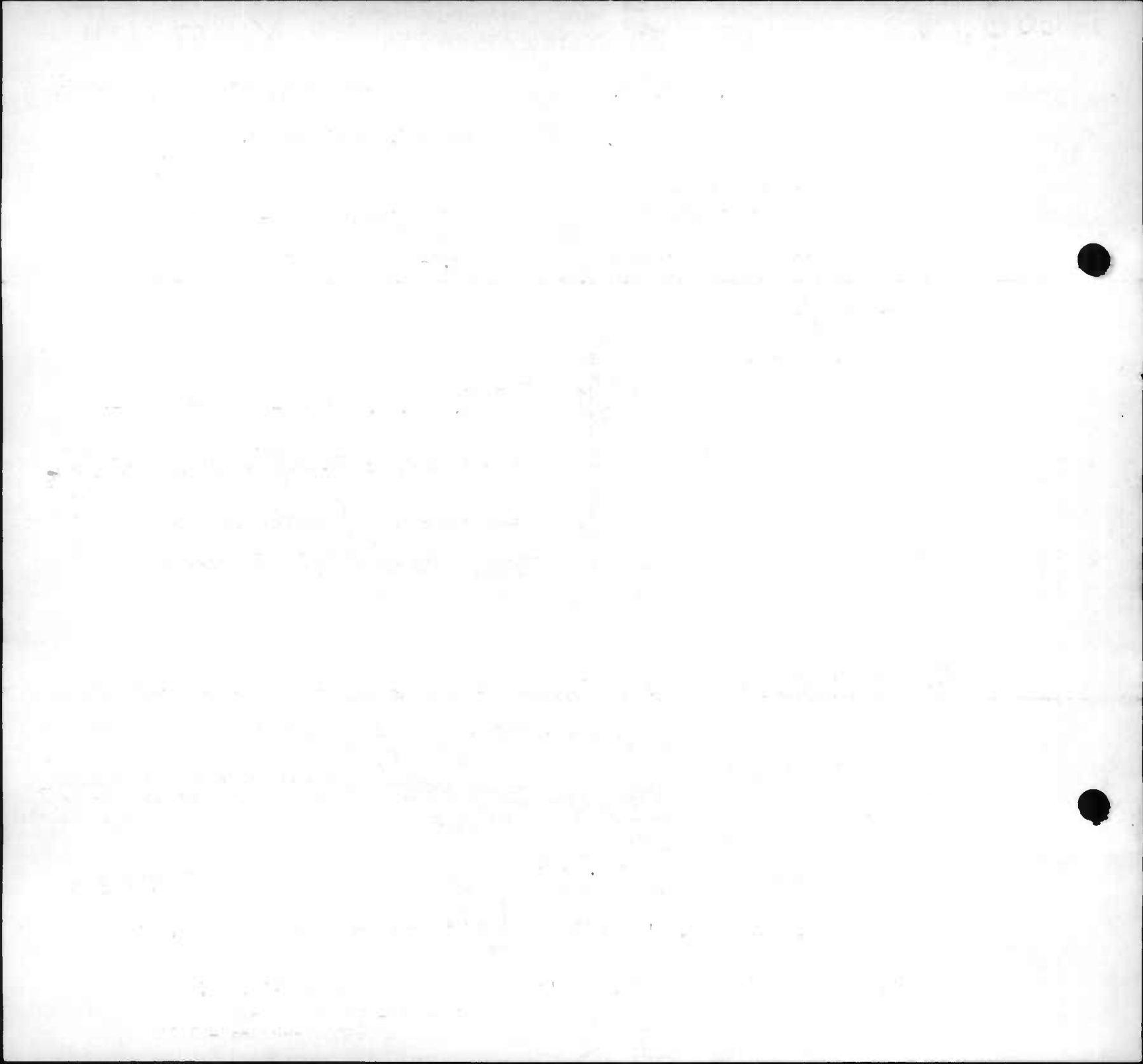
11/11/11 11/11/11 11/11/11  
the future problem 11/11/11

11/11/11  
Richard N. Scott  
Richard N. Scott

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 11301</u>	
BIRTH NO. <u>67 11301</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>JOHN B. TIER, Sr.</u>		2. DATE AND HOUR OF DEATH <u>November 22nd 1967 1:00 A.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>96 House in the Pines (Belvedere)</u>		A. STATE <u>Maryland</u> , B. COUNTY <u>Baltimore Co.</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>53-00</u>			
		D. STREET ADDRESS (If rural, give location) <u>7 Register Avenue-12</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 9-1876</u>	9. AGE (In years last birthday) <u>90</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>James Tier</u>		14. MOTHER'S MAIDEN NAME <u>(?)</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-05-3490</u>		17. INFORMANT ADDRESS <u>Mrs. Edw. R. Briscoe-7 Register Ave-12</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>E 903.10</u>		CAUSE OF DEATH (A) DUE TO <u>Congestive Heart Failure 4 Days</u> (B) DUE TO <u>Bronchial Pneumonia 4 Days</u> (C) <u>Fractured Rt Femur</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>10/12/67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Pinning of Hip</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initiate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Fallen down Bedroom</u>	
21D. TIME OF INJURY (APPROX.) <u>10/11/67</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Slipped on Floor</u> <u>53-00</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>June 1949</u> to <u>22 November 1967</u> , that (I) (we) last saw the deceased alive on <u>21 November 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles F. O'Donnell</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>11/23/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Charles F. O'Donnell</u>		23D. ADDRESS M.D. <u>7501 York Road Baltimore, Md. 21204</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11/25/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Anne's Cemetery</u>	
		24D. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 27 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Mitchell-Wiedefeld Home 6500 York Road-21212</u>	





FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">67 11302</span>	
BIRTH NO. <span style="float: right;">67 11302</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		William Davis Proctor		Nov. 18, 1967 <span style="float: right;">3:30 A.M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <span style="float: right;">Md.</span>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="float: right;">Buckeystown</span>			
8 US Public Health Service Hospital 3100 Wyman Pk. Drive		D. STREET ADDRESS (If rural, give location) <span style="float: right;">60-00</span>			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days Hours Min.
M	Col	Single	10/23/05	62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Farmer		Retired	Md.	USA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Proctor			Henrietta Price		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No		216-22-1855	Records- US PHS Hospital, Balto, Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		MONTHS	
		(B) DUE TO			
		(C) DUE TO			
II		CARCINOMA of PANCREAS			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CARCINOMA Floor of Mouth			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 13, 1967 to Nov. 18, 1967, that (I) (we) last saw the deceased alive on Nov. 18, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  William L. Wilkie				23B. DATE SIGNED  Nov. 23, 1967	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
William L. WILKIE		US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		11-25-67		Fairview	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 27 1967		Robert E. Johnson		Charles W. Frederick Ltd.	

Carcinoma of Pancreas

Carcinoma of Testis

Carcinoma of Mouth

Yes

Yes

William L. McKie  
William L. McKie

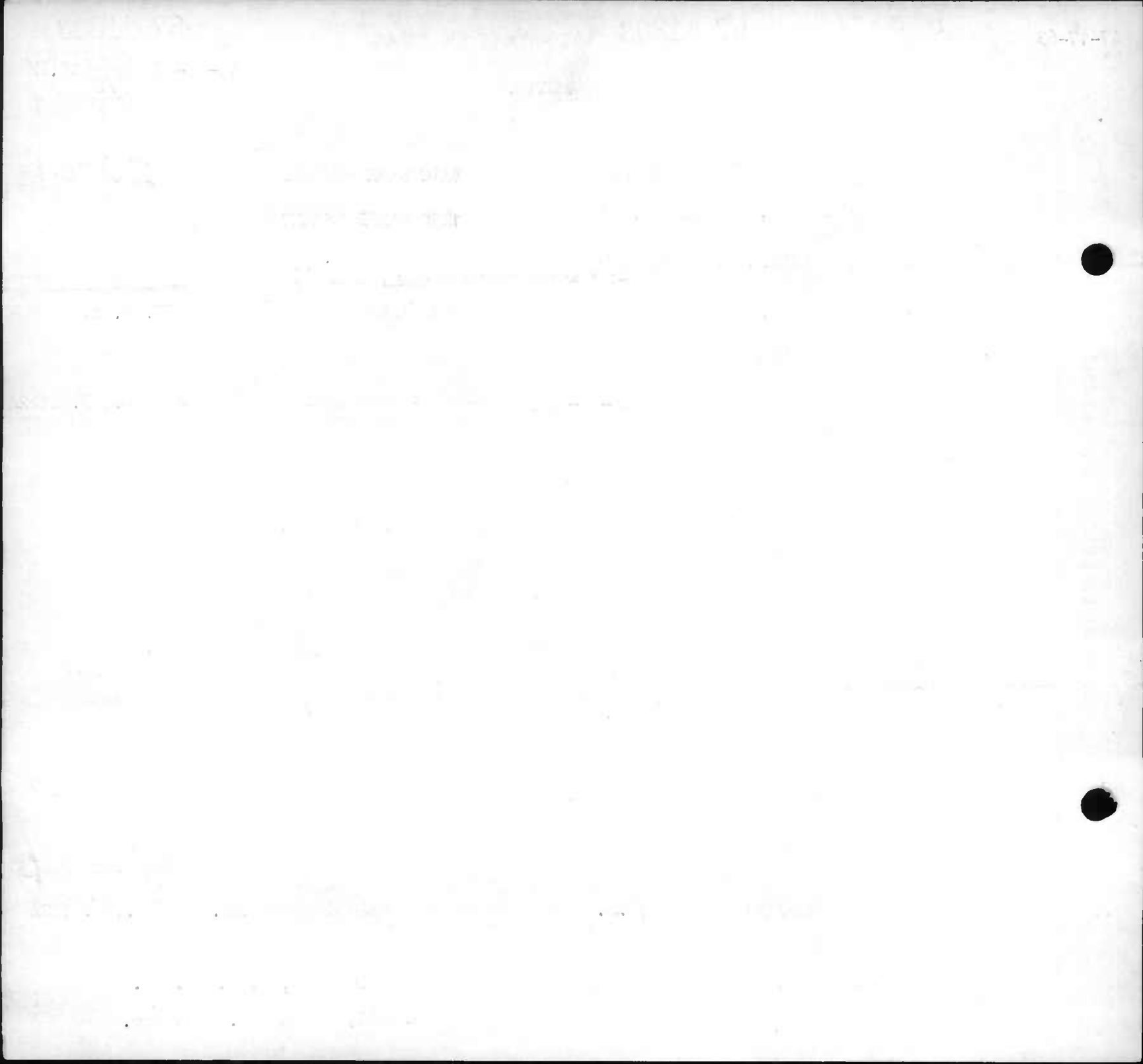
NOV. 23 1962

47-17-63 LB

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-351		67 11303		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11303	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) EMMA M. STUMP				2. DATE AND HOUR OF DEATH 11-22-67 10:PM		10:PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1250 SHARP STREET			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 4-25-1896	9. AGE (In years last birthday) 71	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HENRY LANG				14. MOTHER'S MAIDEN NAME ANNA LANG			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-36-8123		17. INFORMANT BALTIMORE CITY HOSPITALS ADDRESS RECORDS: 4940 EASTERN AVENUE -BALTO., MD. 21224			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH not known not known			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic cerebrovascular disease							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/20 1967 to 11/22 1967 that (I) (we) last saw the deceased alive on 11/22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Benjamin Lechner, MD				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Nov 22, 1967	
23C. PHYSICIAN'S NAME (Type) BENJAMIN LECHNER				23D. ADDRESS 4940 EASTERN AVE. BALTO., MD. 21224 BALTO. CITY HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11 27 67		24C. NAME OF CEMETERY or CREMATORY Holy Cross		24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 27 1967		25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR ADDRESS Mc Cully 130 E. Fort Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">67 11304</span>	
<div style="display: flex; justify-content: space-between;"> <span>67 11304</span> <span>CERTIFICATE OF DEATH</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>M.E. CASE NO.</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>1. NAME OF DECEASED (Type or Print)</span> <span>2. DATE AND HOUR OF DEATH</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</span> <span>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>5. SEX</span> <span>6. RACE</span> <span>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)</span> <span>8. DATE OF BIRTH</span> <span>9. AGE (In years last birthday)</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</span> <span>10B. KIND OF BUSINESS OR INDUSTRY</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>11. BIRTH PLACE (State or foreign country)</span> <span>12. CITIZEN OF WHAT COUNTRY?</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>13. FATHER'S NAME</span> <span>14. MOTHER'S MAIDEN NAME</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</span> <span>16. SOCIAL SECURITY NO.</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>17. INFORMANT</span> <span>ADDRESS</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>18. <u>450.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, esthenia, etc. It means the disease, injury or complication which caused death.)</span> <span>CAUSE OF DEATH</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>19. DATE OF OPERATION</span> <span>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>20A. AUTOPSY? (Yes or No)</span> <span>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)</span> <span>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</span> <span>21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>21F. HOW DID INJURY OCCUR?</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>22. I certify that (I) (the hospital) attended the deceased from <u>June</u> 19<u>67</u> to <u>November 22</u> 19<u>67</u>. that (I) (we) last saw the deceased alive on <u>Nov 22</u> 19<u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>23A. SIGNATURE <u>Joseph C. Matchar</u></span> <span>23B. DATE SIGNED</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>23C. PHYSICIAN'S NAME (Type)</span> <span>23D. ADDRESS</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>24A. BURIAL CREMATION, REMOVAL (Specify)</span> <span>24B. DATE</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>24C. NAME of CEMETERY or CREMATORY</span> <span>24D. LOCATION (City, town, or county) (State)</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>25A. DATE REC'D BY HEALTH DEPT.</span> <span>25B. NAME OF REGISTRAR</span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>25C. FUNERAL DIRECTOR</span> <span>ADDRESS</span> </div>					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
<div style="display: flex; justify-content: space-between;"> <span>K-523</span> <span>67 11305</span> </div>				<div style="display: flex; justify-content: space-between;"> <span>67 11305</span> <span>67 11305</span> </div>	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Katherine Knight		11-24-67 7:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH Home & Hospital		A. STATE Md. B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE 6-05			
		D. STREET ADDRESS (If rural, give location)			
		The Home - CHURCH Home			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
F	White	widowed	Dec. 31, 1993	73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED - Hostess		Schimunek Funeral Home		Baltimore, Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Albert Neetcke			Elizabeth Nicolaus		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
		216-44-2400		Nov. 8, 1965	
				self - 3331 Brehms Lane, Balto. Md. 21213	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.01		(A) DUE TO		ARTERIOSCLEROTIC HEART DISEASE	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO		YEARS	
ANTECEDENT CAUSES		(C) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Aug 4 1965 to Nov 24 1967, that (I) (we) last saw the deceased alive on Nov 23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Ephraim Barzaga				11-24-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Ephraim B. BARZAGA				CHURCH Home & Hosp. BALTO. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		11/27/67		Woodlawn Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Woodlawn, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 27 1967		Robert E. Tarkenton		Schimunek Funeral Home, Inc.	
				3331 Brehms Lane	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11306		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11306	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				ANGELINA T. CRIVELLO	
2. DATE AND HOUR OF DEATH		NOV. 23, 1967 5:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			
MONTEBELLO STATE HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3733 Elmley Avenue, Balto., Md. 21213			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH March 9, 1889	9. AGE (In years last birthday) 78 yrs.	10. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME Philip Spampinato			14. MOTHER'S MAIDEN NAME Angela Pistorio		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-48-3373		17. INFORMANT Philip Crivello, son, 7705 Winterhaven Rd. #37	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 357X I Quadruparesis Lesion of Cervical cord.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 YEARS	
19. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 5-12-1964 to 11-23-1967, that (H) (we) last saw the deceased alive on 11-23-1967 and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Irving L. Cooperstein				23B. DATE SIGNED 11-23-67	
23C. PHYSICIAN'S NAME (Type) Irving L. Cooperstein				23D. ADDRESS M.D. MONTEBELLO HOSP., BALTO. MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/25/67		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery	
24D. LOCATION Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 27 1967			
25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane #13			

Went to the bank

Quadrant  
Landing (at 1000 ft)

Chickadee at 1000 ft  
No.

11-23

Young & Cooper

Monte Carlo

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
67 11307					CERTIFICATE OF DEATH					Registered No. 67 11307				
BIRTH NO. 67 11307 M.E. CASE NO. DOLORIS 1. NAME OF DECEASED (Type or Print) Volker, Dolores -										2. DATE AND HOUR OF DEATH Nov. 21-67 8:20 AM				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) NORTH CHARLES GEN. HOSP.										4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY A.A. Co C. CITY OR TOWN (If outside city limits, write RURAL and give township) Queen's Park 52-00 D. STREET ADDRESS (If rural, give location) 28 Robinson Rd.				
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) M		8. DATE OF BIRTH 10-3-13		9. AGE (In years last birthday) 54		10. If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY @ home		11. BIRTHPLACE (State or foreign country) Md -				12. CITIZEN OF WHAT COUNTRY? America				
13. FATHER'S NAME James Lowe						14. MOTHER'S MAIDEN NAME Addie Welch								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Hosp. records				ADDRESS				
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										CAUSE OF DEATH (A) DUE TO acute gastro intestinal hem. from superficial stress ulcers CVA (B) DUE TO Hypertension (C)		INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) No.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from 11-14 1967 to Nov. 21 1967, that (I) (we) last saw the deceased alive on Nov. 21 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE [Signature]						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED Nov. 21-67				
23C. PHYSICIAN'S NAME (Type) DR. FERNANDO JULIO						23D. ADDRESS M.D. NORTH CHARLES GEN. HOSP.								
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial				24B. DATE 11/24/67		24C. NAME OF CEMETERY or CREMATORY Beth National				24D. LOCATION (City, town, or county) (State) Beth MD				
25A. DATE REC'D BY HEALTH DEPT. NOV 27 1967				25B. NAME OF REGISTRAR Robert S. Barranco				25C. FUNERAL DIRECTOR Robert S. Barranco						
VS 150-REV. 11/765						ADDRESS								



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 11308		67 11308		67 11308	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		HOWARD, JOHN E.		7:30 PM 11-21-67 7 <sup>30</sup> PM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
MARYLAND GENERAL HOSP		MD			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
M		W		M	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
RET-?		?		2-1-02 65	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
MD		U.S.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
JOHN HOWARD		MARY CHARTERS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or both) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO.		212 078658		CHART	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) CARCINOMA of Colon		1 yr. (?)	
ANTECEDENT CAUSES		(B) Cirrhosis of Liver		several yrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
11/7/67		CA of Colon		NO.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from		10-4		19 to 11-21 1967.	
that (I) (we) last saw the deceased alive on		11-21		1967 and that in (my) (our) opinion death occurred on the date	
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
FRANK J. ZORICK M.D.		11/21/67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
FRANK J. ZORICK		MARYLAND General Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		Nov 24, 1967		Christ Church Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 27 1967		Robert E. Farkman		A.D. Farkman & Son, Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

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67 11309

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 67 11309

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

William Charlie Murphy, Jr.

2. DATE AND HOUR OF DEATH

Nov. 21, 1967

2:30 P

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(If not in hospital or institution, give street  
address or location)

US Public Health Service Hospital  
3100 Wyman Pk. Drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1814 Wilhelm Ave.

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

6/21/13

9. AGE (In years  
last birthday)

54

If Under 1 Yr.  
Months Days

If Under 24 Hrs.  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Chief Steward

10B. KIND OF BUSINESS OR INDUSTRY

Seafarer

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF  
WHAT COUNTRY?  
USA

13. FATHER'S NAME

Wm. C. Murphy

14. MOTHER'S MAIDEN NAME

Ella Ewell

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

231-10-3662

17. INFORMANT

ADDRESS

Records- US PHS Hospital, Balto, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) Liver failure  
DUE TO

years

(B) Laennec's cirrhosis  
DUE TO

years

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Multiple myeloma

3 years

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At  
Work ☐

Not White  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Sept. 18 19 67 to Nov. 21 19 67,  
that (I) (we) last saw the deceased alive on Nov. 21 19 67 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Robert Wainer

M.D.

Attending  
Phys. ☐

Med.  
Director ☐

Staff  
Phys. ☒

23B. DATE SIGNED

11/21/67

23C. PHYSICIAN'S  
NAME (Type)

Robert Wainer, SA Surg (R)

M.D.

23D. ADDRESS

US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

11/24/67

24C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.

NOV 27 1967

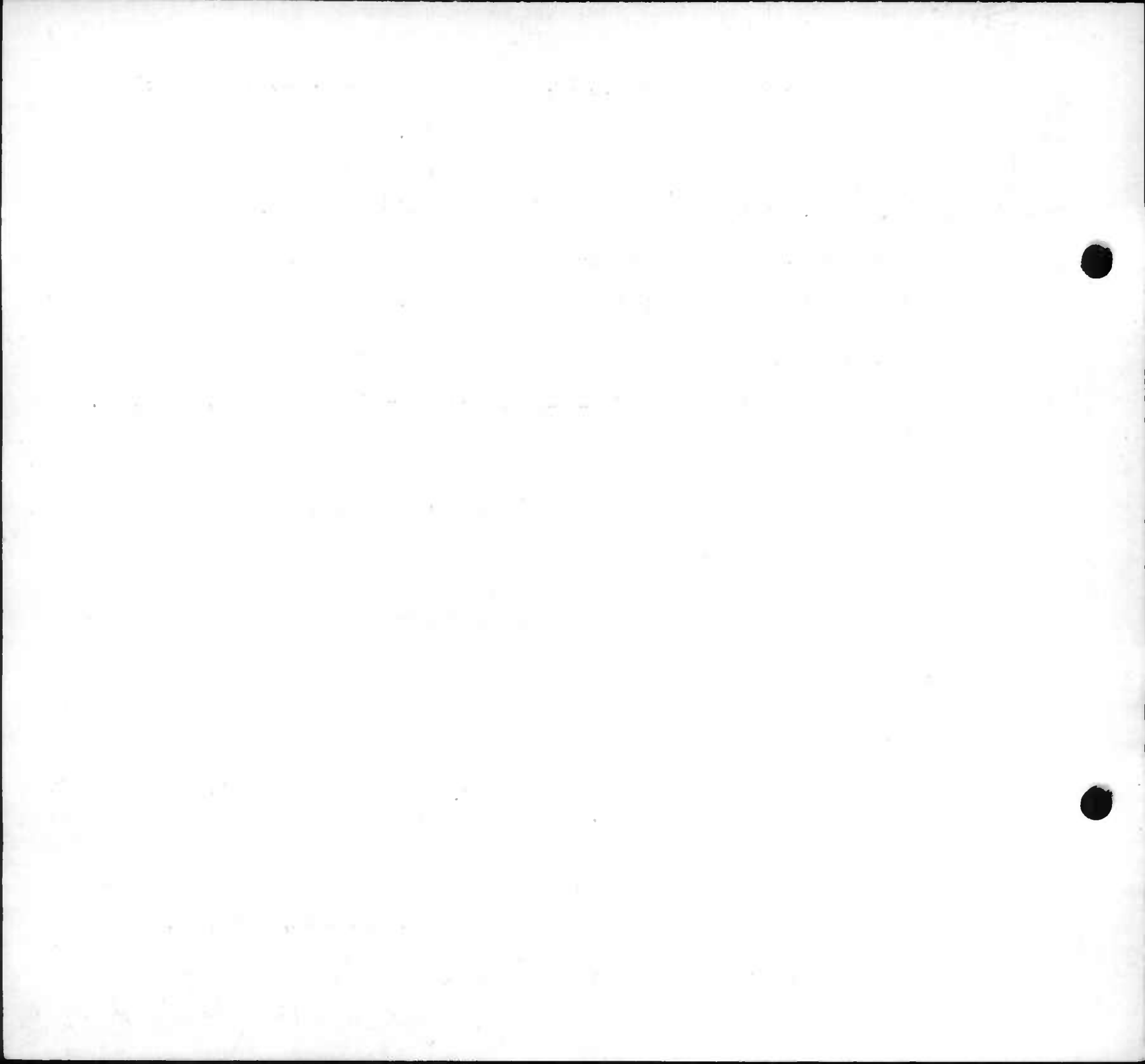
25B. NAME OF REGISTRAR

Robert E. Fairbank

25C. FUNERAL DIRECTOR

Philip J. Grech 1211 Chesaco Ave.

ADDRESS





1  
C-400

67 11310 BALTIMORE CITY HEALTH DEPARTMENT

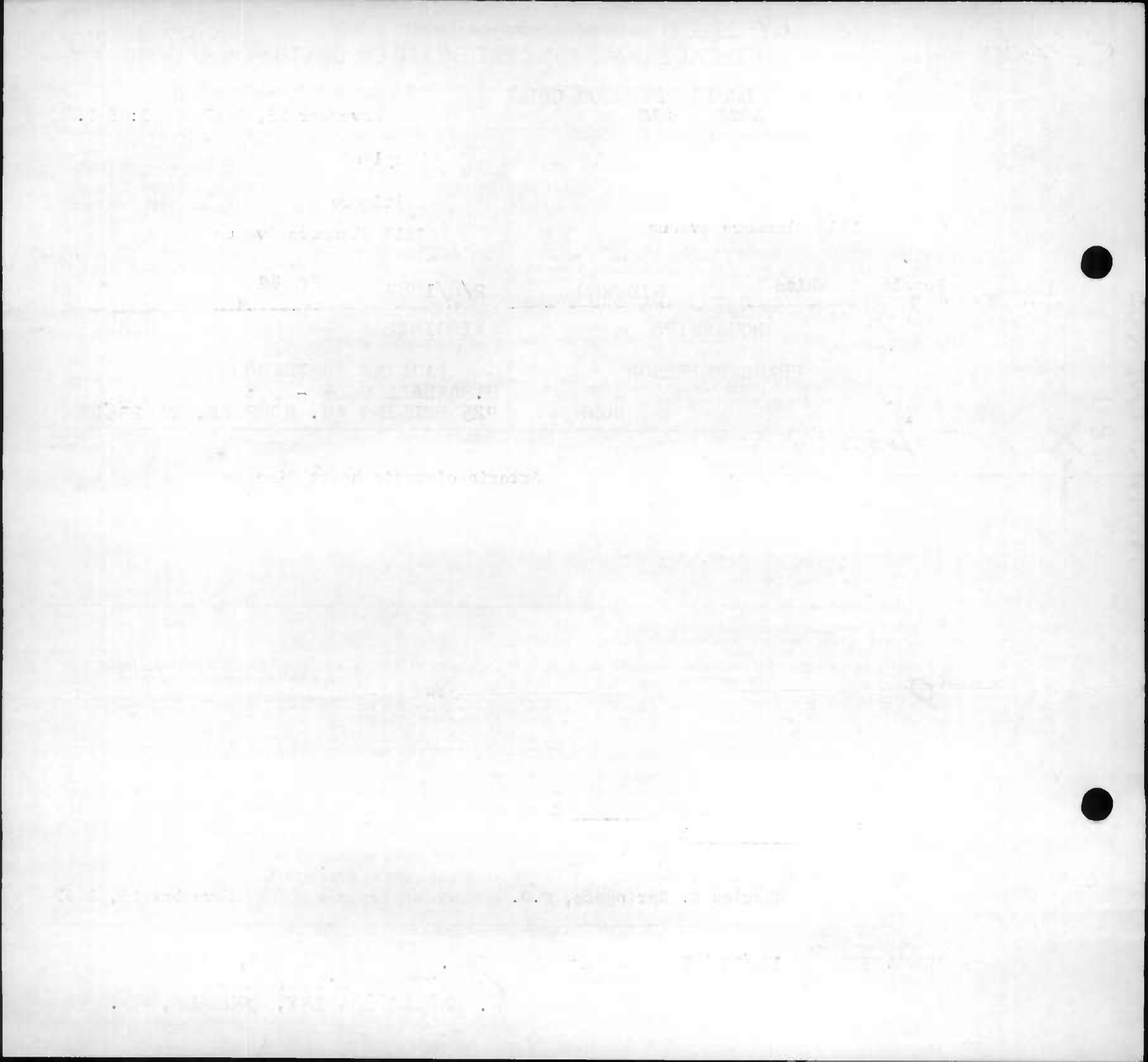
67 11310

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

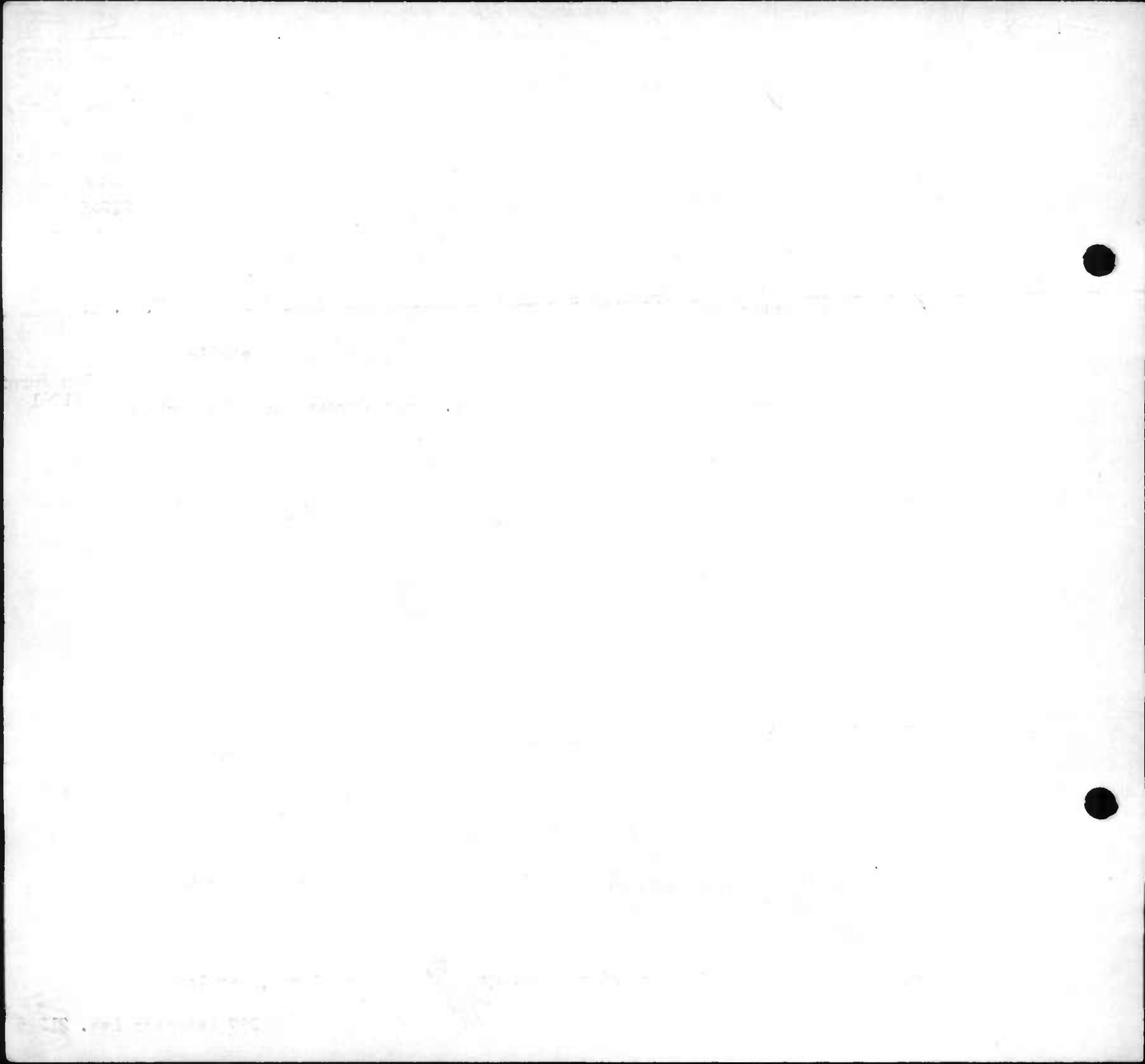
M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>LUCIE PETERSON COLE</b> <del>LUCY COLE</del>		2. DATE AND HOUR PRONOUNCED DEAD <b>November 25, 1967 3:45 P.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>2918 Glenmore Avenue</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>27-06</b> D. STREET ADDRESS (If rural, give location) <b>2918 Glenmore Avenue</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>2/8/1887</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	9. AGE (in years last birthday) <b>80</b>
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FRANK PETERSON</b>		14. MOTHER'S MAIDEN NAME <b>PAULINE GREENWOOD</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMATION <b>R. RANDALL COLE - SON</b>		ADDRESS <b>925 BOLLING AV. NORFOLK, VA 23508</b>	
18. CAUSE OF DEATH I <b>420.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic heart disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> November 26, 1967			
23A. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23B. DATE <b>11/27/67</b>	
23C. NAME OF CEMETERY or CREMATORY <b>GREENMOUNT CRE.</b>		23D. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>	
24C. FUNERAL DIRECTOR <b>W. Brooks Bradley</b>		ADDRESS <b>DUNDALK, MD.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPT.		Registered No.	
67 11311		<b>CERTIFICATE OF DEATH</b>		67 11311	
1. NAME OF DECEASED (Type or Print) <b>GILSON, EVELYN BARBARA</b>			2. DATE AND HOUR OF DEATH <b>November 23, 1967 3:45 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>36 FRANKLIN SQUARE HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>9.9C</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>36 FRANKLIN SQUARE HOSPITAL</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Brooklyn Park</b>		
D. STREET ADDRESS (If rural, give location) <b>9 W. 11th Ave.</b>			21225		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>DIVORCED</b>	8. DATE OF BIRTH <b>6/12/15</b>	9. AGE (In years last birthday) <b>52</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Disabled Inspector</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Crown Cork &amp; Seal</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland (Baltimore)</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Anten Pasek</b>			
14. MOTHER'S MAIDEN NAME <b>Josephine - Sobelik</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Mrs. Norma Jordan</b>			
ADDRESS <b>Glen Burn 21061</b>		18. <b>199-21</b>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cancer</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr &amp; 2 mos</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO <b>metastatic cancer</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(B) DUE TO		
(C) DUE TO					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>11/11/1967</b> to <b>11/23/1967</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>11/23/1967</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(we)</b> <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Chong jin Wang</b>				23B. DATE SIGNED <b>Nov. 23, 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>M.D.</b>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/27/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Bohemian Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Tabor</b>		25C. FUNERAL DIRECTOR <b>McCall Funeral Home</b>			
ADDRESS <b>237 Patapsco Ave. 21225</b>					



1  
M-650

67 11312

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

67 11312

BIRTH NO.

M.E. CASE NO.

## 1. NAME OF DECEASED

(Type or Print)

Dora B. Marine

## 2. DATE AND HOUR PRONOUNCED DEAD

November 20, 1967

2:12 P.M.

## 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

40 St. Agnes Hospital

## 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

## C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

## D. STREET ADDRESS (If rural, give location)

322 Lee Drive

## 5. SEX

F.

## 6. RACE

W.

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

## 8. DATE OF BIRTH

Dec. 29, 1902

9. AGE (In years  
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

House wife

## 10B. KIND OF BUSINESS OR INDUSTRY

## 11. BIRTHPLACE (State or foreign country)

Dorchester Co. Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S. A.

## 13. FATHER'S NAME

Alfred Brinsfield

## 14. MOTHER'S MAIDEN NAME

Margaret E. Marine

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

## 17. INFORMANT

## ADDRESS

Balto. Md. 21228

Rev. Frederick B. Marine 322 Lee Drive

18. 422.1 I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardio-vascular  
DUE TO disease.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Obesity

MEDICAL CERTIFICATION

## 19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

## 20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

## 21E. INJURY OCCURRED

## 21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
WORK AT WORK

## 22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

Nov. 20, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

## 23B. DATE

Nov. 25, 1967 Eldorado Cem.

## 23C. NAME of CEMETERY or CREMATORY

## 23D. LOCATION

(City, town, or county)

(State)

Dorchester, Co. Maryland

## 24A. DATE REC'D BY HEALTH DEPT.

## 24B. NAME OF REGISTRAR

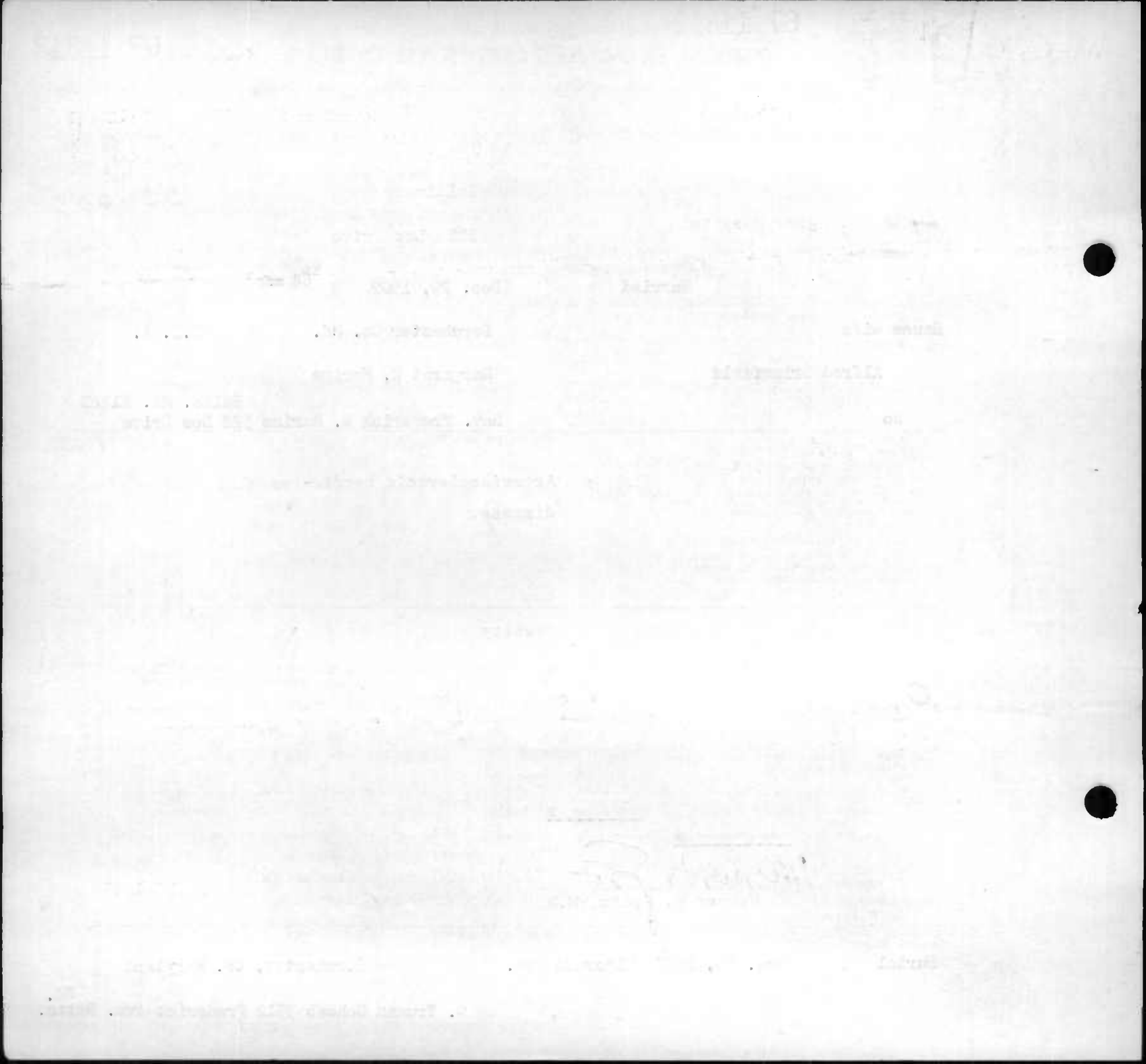
## 24C. FUNERAL DIRECTOR

## ADDRESS

NOV 27 1967

Robert E. Farley, M.D.

G. Truman Schwab 3512 Frederick Ave. Balto. Md.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>Registered No. <u>67 11313</u></p>	
<p>BIRTH NO. <u>C-516</u></p> <p>M.E. CASE NO. <u>67 11313</u></p>		<p>1. NAME OF DECEASED (Type or Print) <u>LAVENIA CHAMBERS</u></p>	
<p>2. DATE AND HOUR OF DEATH <u>12<sup>30</sup> PM 11/23/67</u></p>		<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p>	
<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u></p>		<p>5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>JOHNS HOPKINS HOSPITAL</u> <u>33</u></p>	
<p>6. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u></p>		<p>7. STREET ADDRESS (If rural, give location) <u>5504 OLD FREDERICK ROAD</u></p>	
<p>8. SEX <u>FEMALE</u></p>	<p>9. RACE <u>WHITE</u></p>	<p>10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u></p>	<p>11. DATE OF BIRTH <u>8-20-98</u></p>
<p>12. AGE (In years last birthday) <u>69</u></p>		<p>13. If Under 1 Yr. Months: Days: Hours: Min.</p>	<p>14. If Under 24 Hrs. Hours: Min.</p>
<p>15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>		<p>16. KIND OF BUSINESS OR INDUSTRY <u>At Home</u></p>	
<p>17. BIRTHPLACE (State or foreign country) <u>Virginia</u></p>		<p>18. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>19. FATHER'S NAME <u>DEWITT HANSEN</u></p>		<p>20. MOTHER'S MAIDEN NAME <u>MARY ELLEN LOWMAN</u></p>	
<p>21. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u></p>		<p>22. SOCIAL SECURITY NO.</p>	<p>23. INFORMANT <u>Shelly Chambers</u></p>
<p>24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>260X I</u></p>		<p>25. CAUSE OF DEATH (A) DUE TO <u>Myocardial infarction</u> (B) DUE TO <u>Diabetes mellitus</u> (C) DUE TO <u>Rhabdomyosarcoma</u></p>	
<p>26. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>27. INTERVAL BETWEEN ONSET AND DEATH <u>Yrs</u></p>	
<p>28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>			
<p>29. DATE OF OPERATION <u>2</u></p>		<p>30. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>31. AUTOPSY? (Yes or No) <u>Yes</u></p>		<p>32. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>33. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>34. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>35. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>36. HOW DID INJURY OCCUR?</p>	
<p>37. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p>38. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>39. I certify that (I) (this hospital) attended the deceased from <u>Nov 23 19 67</u> to <u>Nov 23 19 67</u>, that (I) (we) last saw the deceased alive on <u>Nov 23 19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>40. SIGNATURE <u>Marvin C. Mengel</u></p>		<p>41. DATE SIGNED <u>11/23/67</u></p>	
<p>42. PHYSICIAN'S NAME (Type) <u>MARVIN C. MENGEL</u></p>		<p>43. ADDRESS <u>601 N. BROADWAY BALTIMORE, MD</u></p>	
<p>44. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>45. DATE <u>11-27-67</u></p>	
<p>46. NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u></p>		<p>47. LOCATION (City, town, or county) (State) <u>Balto, Md.</u></p>	
<p>48. DATE REC'D BY HEALTH DEPT. <u>NOV 27 1967</u></p>		<p>49. NAME OF REGISTRAR <u>R. B. E. Jackson</u></p>	
<p>50. FUNERAL DIRECTOR <u>McCully</u></p>		<p>51. ADDRESS <u>130 E. Fort Ave</u></p>	

That's why we're  
not all there  
in the end

204

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Wm. C. C. C. C.



5-160

67 11314

BALTIMORE CITY HEALTH DEPARTMENT

67 11314

BIRTH NO. 67-16465 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

RONNIE SHAFFER JR.

2. DATE AND HOUR PRONOUNCED DEAD

November 22, 1967 7:10 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38 University Hospital  
4217-Hamilton-Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4217 Hamilton Ave.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

--

8. DATE OF BIRTH

Aug. 22, 1967

9. AGE (In years  
last birthday)

3 Mo.

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

--

10B. KIND OF BUSINESS OR INDUSTRY

--

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Ronnie Lee Shaffer

14. MOTHER'S MAIDEN NAME

Shirly Ann Lee Cash

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

--

17. INFORMANT

Henretta M. Mitchell

ADDRESS

510 Evesham Ave.

Balto. Md. 21212

18. E902.0 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Subdural Hematoma, Massive

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

4217 Hamilton Ave.

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)  
11 14 67 ?

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Baby fell from bed

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

*Edward F. Wilson*

M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/24/1967

23C. NAME OF CEMETERY or CREMATORY

Wm C. Price Private Cemetery Glencove, Maryland

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 27 1967

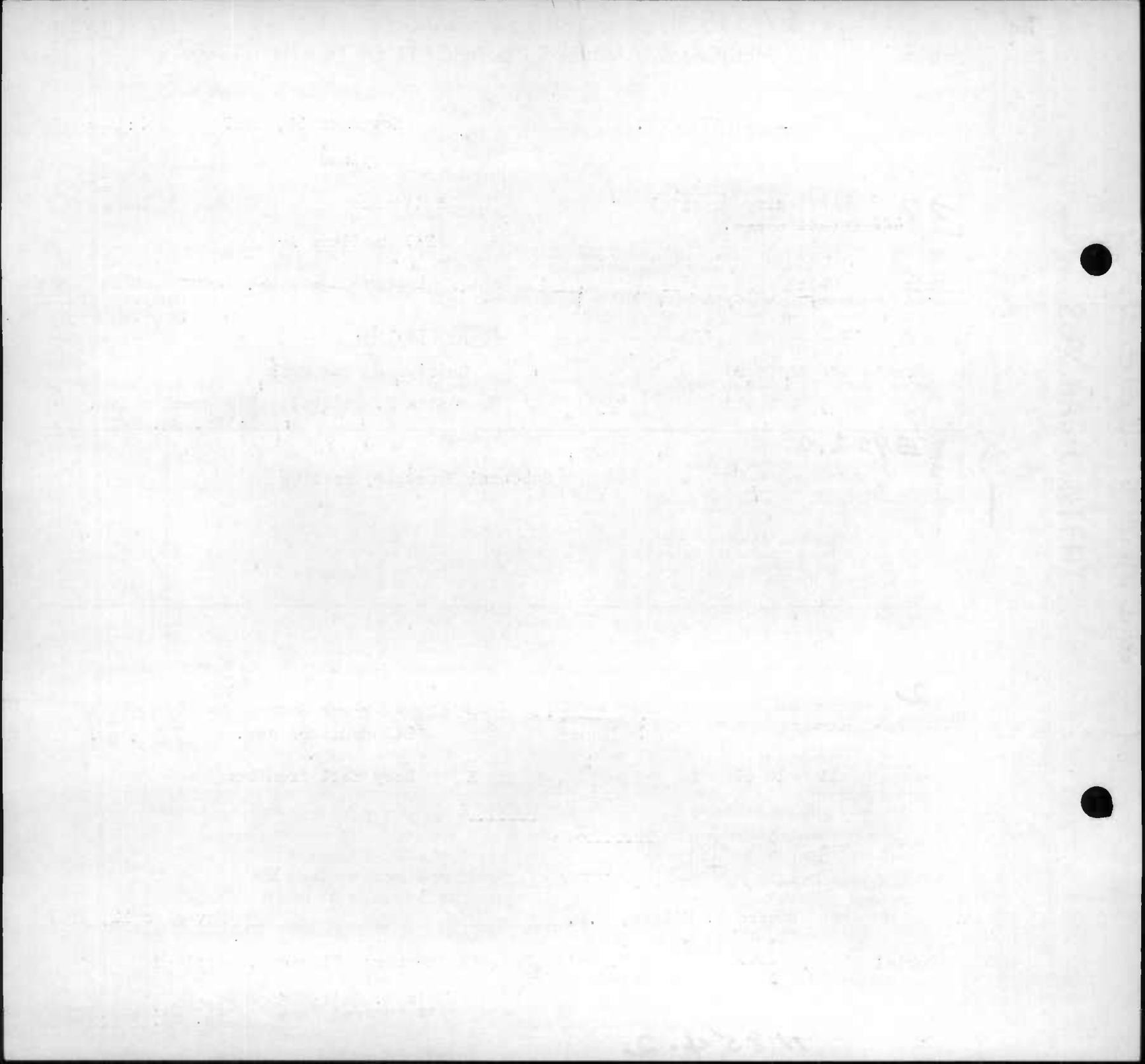
24B. NAME OF REGISTRAR

*Robert E. Jankins*

24C. FUNERAL DIRECTOR

Eugenia K. Seitz 5209 York Rd.  
Seitz Funeral Home Balto. Md. 21212

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11315 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH** Registered No. 67 11315

BIRTH NO. M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>EDNA RHOTEN</b>		2. DATE AND HOUR OF DEATH <b>11/21/67 10 AM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE Co</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 53-00</b> D. STREET ADDRESS (If rural, give location) <b>47 DUNKIRK RD.</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>8/8/27</b>	9. AGE (In years lost birthday) <b>40</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>Pikesville, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles E. Alder, Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Julia HARRIS MAE</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-22-0766</b>	17. INFORMANT <b>Mr. Robert R. Rhoten, 47 Dunkirk Rd., Baltimore 12, Md.</b>		
18. CAUSE OF DEATH A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Uremia</b> B. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>UNILATERAL OBSTRUCTION</b> <b>Carcinoma of Rectum</b> C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>					
19A. DATE OF OPERATION <b>10/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Squamous Ca - Rectum</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NA</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NA</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>NA</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> <b>NA</b> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>NA</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 19 65</b> to <b>NOVEMBER 21 19 67</b> , that (I) (we) last saw the deceased alive on <b>Nov 20 19 67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>F. J. Scarpa, M.D.</b>				23B. DATE SIGNED <b>11/21/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>FRANCIS J. SCARPA</b>		23D. ADDRESS M.D. <b>JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Nov 25 1967</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Pikesville, Balt Co, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Frank H. Jewell</b>		25D. ADDRESS <b>Pikesville 8, Md.</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11316

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

67 11316

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

SMALLWOOD, CLARENCE EDWARD

2. DATE AND HOUR OF DEATH

NOVEMBER 23, 1967

11:00A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

40

ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND HOWARD COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

ELLCOTT CITY

63-00

D. STREET ADDRESS (If rural, give location)

12 ST. PAUL ST. 21043

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
SEPARATED

8. DATE OF BIRTH

3-8-97

9. AGE (In years  
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.  
Months: Days Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CLARENCE E. SMALLWOOD

14. MOTHER'S MAIDEN NAME

MARY ANN STEWART SMALLWOOD

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WW I

16. SOCIAL  
SECURITY NO.

217-17-3084

17. INFORMANT

ADDRESS

ST. AGNES HOSPITAL RECORDS

18. 163X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) DUE TO

Tumoral Lesion

(B) DUE TO

Disseminated Metastasis

(C) DUE TO

Carcinoma of the lung

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 21 1967 to NOVEMBER 23 1967,  
that (I) (we) last saw the deceased alive on NOVEMBER 23 1967 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

11/23/67

23C. PHYSICIAN'S  
NAME (Type)

ALEJANDRO MEJIA

M.D.

23D. ADDRESS

BALTIMORE, MD 21229  
ST. AGNES HOSP; CATON & WILKENS AVES.24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

11-27-67

24C. NAME of CEMETERY or CREMATORY

Trinity Chapel

24D. LOCATION

(City, town, or county)

Ellicott City, Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 27 1967

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Higinbotham - Slack  
Funeral Home

ADDRESS

Ellicott City  
Md.

ADD: 1 NOVEMBER 21, 1952 CLARENCE E. SHALLWOOD

WYOMING, WASH. D.C.

ELLIOTT CITY

12 ST. PAUL ST. 2100

ST. ANNE'S HOSPITAL

NO

1-1-52

SEPARATED

WHITE

WIFE

1-1-52

MARYLAND

WITNESSED

MARY ANN STEWART CHAMBERLAIN

CLARENCE E. SHALLWOOD

12 ST. PAUL ST. 2100

WIFE

YES

*Personal Property  
Discontinued  
Commonwealth of Maryland*

WYOMING, WASH. D.C. NOVEMBER 21, 1952

ST. ANNE'S HOSPITAL  
WYOMING, WASH. D.C.  
NOVEMBER 21, 1952

*My wife  
Mary Ann*

G-400

67 11317 BALTIMORE CITY HEALTH DEPARTMENT

67 11317

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) James 2. DATE AND HOUR PRONOUNCED DEAD November 22, 1967 11:17 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CHARLES J. GILL 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial 5. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

6. STREET ADDRESS (If rural, give location) 4630 Marble Hall Rd.

5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married 8. DATE OF BIRTH 2-26-1934 9. AGE (In years last birthday) 33

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bethlehem Steel Co. 10B. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland 11. BIRTHPLACE (State or foreign country) U.S.A.

12. CITIZEN OF WHAT COUNTRY? U.S.A. 13. FATHER'S NAME Charles Paul Gill 14. MOTHER'S MAIDEN NAME Regina Yuhn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown); (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 213-32-2431 17. INFORMANT Mrs Willia Mae Gill ADDRESS 1806 Weyborn Road 212

18. CAUSE OF DEATH E 812.4 Multiple traumatic injuries INTERVAL BETWEEN ONSET AND DEATH 33

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple traumatic injuries

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED YES 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Road 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Old North Point Rd. 275' N. of Mathai Ave.

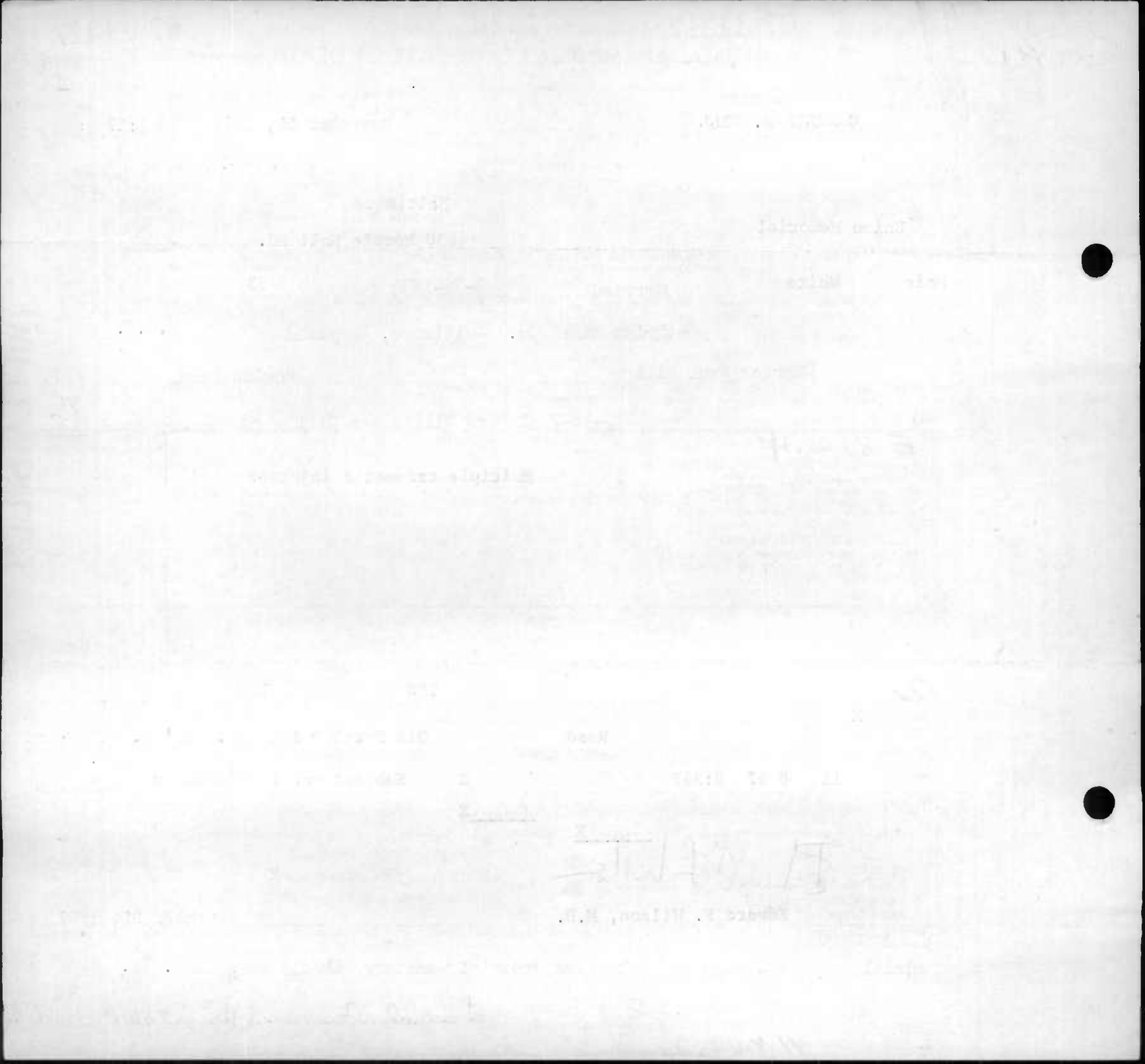
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 11 8 67 8:36P 21E. INJURY OCCURRED WHILE AT ☐ WDRK ☒ NDT WHILE AT WDRK Subject was a pedestrian

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ CHIEF MEDICAL EXAMINER ☐ M.D. ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ ACTUAL SIGNATURE Edward F. Wilson DATE SIGNED November 22, 1967

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 11-25-1967 23C. NAME OF CEMETERY OR CREMATORY Lake View Memorial Cemetery 23D. LOCATION (City, town, or county) (State) Liberty Road Balto. Co. Md

24A. DATE REC'D BY HEALTH DEPT. NOV 27 1967 24B. NAME OF REGISTRAR Robert E. Fairbank 24C. FUNERAL DIRECTOR Laessle Funeral Home ADDRESS 401 Belair Road

N 869.2 11317





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 11318		67 11318		67 11318	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
ZAVOYNA, HELEN			NOVEMBER 25, 1967 2:40 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
ST AGNES HOSPITAL CATON & WILKENS BALTIMORE, MARYLAND 21229			MARYLAND		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			BALTIMORE 21228		
D. STREET ADDRESS (If rural, give location)			114 DELREY AVENUE		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
FEMALE	WHITE	MARRIED	03/04/18	49	U.S.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
HOUSEWIFE			NEW YORK		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
			U.S.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JOSEPH KOHUT			MARY CHUMA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			058-10-6809		
17. INFORMANT			ADDRESS		
			ST AGNES HOSPITAL'S RECORDS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) Heart failure		
ANTECEDENT CAUSES			(B) Cor pulmonale		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 22 19 67 to NOVEMBER 25 19 67, that (X) (we) last saw the deceased alive on NOVEMBER 25 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
GABRIELA BRAUN					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
GABRIELA BRAUN				CATON & WILKENS AVES., BALTO., MD. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		Nov. 28/67		Lake View Memorial Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. NAME OF REGISTRAR		24F. FUNERAL DIRECTOR	
Carroll Co. Md		Robert E. Taylor, M.D.		Funeral Home	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 27 1967		Robert E. Taylor, M.D.		Farley Cavanaugh	
25D. ADDRESS		25E. ADDRESS		25F. ADDRESS	
6601 Frederick Ave.					

2:30 A.

NOVEMBER 22, 1957

WINTER, 1957

03/04/58

114 BELLEVUE

114 BELLEVUE

114 BELLEVUE

114 BELLEVUE

03/04/58

03/04/58

NEW YORK

NEW YORK

NEW YORK

NEW YORK

03-15-58 ST AGNES HOSPITAL

07

NOVEMBER 22

XX

NOVEMBER 22

NOVEMBER 22

XXXX

X

X

X

GOOD ILLI

CATON & WICKES

W-426

67 11319 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11319

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HOWARD E. WALKER

2. DATE AND HOUR PRONOUNCED DEAD

November 22, 1967 6:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 307 S. Mount Street 21223

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

307 S. Mount Street 21223

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

1/27/84

9. AGE (In years  
last birthday)

84 83

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

B &amp; O R. R.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Samuel B. Walker

14. MOTHER'S MAIDEN NAME

Sarah - -

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

705-05-2555

17. INFORMANT

ADDRESS

21227

Mrs. Vernon F. Hartman, 1255 Circle Drive

18.

426.0 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic heart disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATURE

Charles S. Springate

M.D. ASSISTANT MEDICAL EXAMINER ☒EXAMINER'S  
NAME (Type)Charles S. Springate, M.D. ASSOCIATE MEDICAL EXAMINER ☐

November 23, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/27/67

23C. NAME of CEMETERY or CREMATORY

Lorraine Park Cemetery

23D. LOCATION

Baltimore

Md.

24A. DATE REC'D BY HEALTH DEPT.

NOV 27 1967

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Ave. 21229

ADDRESS

1. The purpose of this document is to provide information regarding the activities of the [redacted] and the [redacted] in the [redacted] area.

2. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

3. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

4. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

5. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

6. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

7. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

8. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

9. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

10. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11320 <b>CERTIFICATE OF DEATH</b>		Registered No. 67 11320	
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Nellie Stang</b>		2. DATE AND HOUR OF DEATH <b>11/23/67 3:00 p.m.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>43 SOUTH BALTIMORE GENERAL HOSPITAL</b> (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>A. G. Co</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Glen Burnie 52-00</b> D. STREET ADDRESS (If rural, give location) <b>510 Hamlen Road</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>2/21/09</b>
9. AGE (In years last birthday) <b>58</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>
11. BIRTHPLACE (State or foreign country) <b>Port Chester, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Harry Latchford</b>		14. MOTHER'S MAIDEN NAME <b>Nellie St. John</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>	17. INFORMANT <b>Aubrey Stang - same</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>422.11-260X Acute Pulmonary Edema</b> <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>(A) Pulmonary Infection</b> <b>(B) Atherosclerotic C. Vas. Disease</b> <b>(C) Renal Failure</b>		CAUSE OF DEATH <b>Interval Between Onset and Death</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetes mellitus</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>10 PM 8:00 PM</b>	
22. I certify that (1) (this hospital) attended the deceased from <b>11-23-67</b> 19 to <b>11-23-67</b> 19 that (2) (we) lost saw the deceased alive on <b>11-23-67</b> 19 and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>C. Carter</b>		23B. DATE SIGNED <b>11/24/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>C. CARTER, M.D.</b>		23D. ADDRESS <b>S.B.G.H. - 1213 Light St.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-27-1967</b>	
24C. NAME of CEMETERY or CREMATORY <b>George Washington Cemetery Prince George Co., Maryland</b>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>		25B. NAME OF REGISTRAR <b>George J. Gonce</b>	
25C. FUNERAL DIRECTOR <b>George J. Gonce-4001 Ritchie Hwy., Baltimore</b>		ADDRESS	

First February 1894  
11-13-94

February 1894  
February 1894  
February 1894  
February 1894

11-13-94  
11-13-94

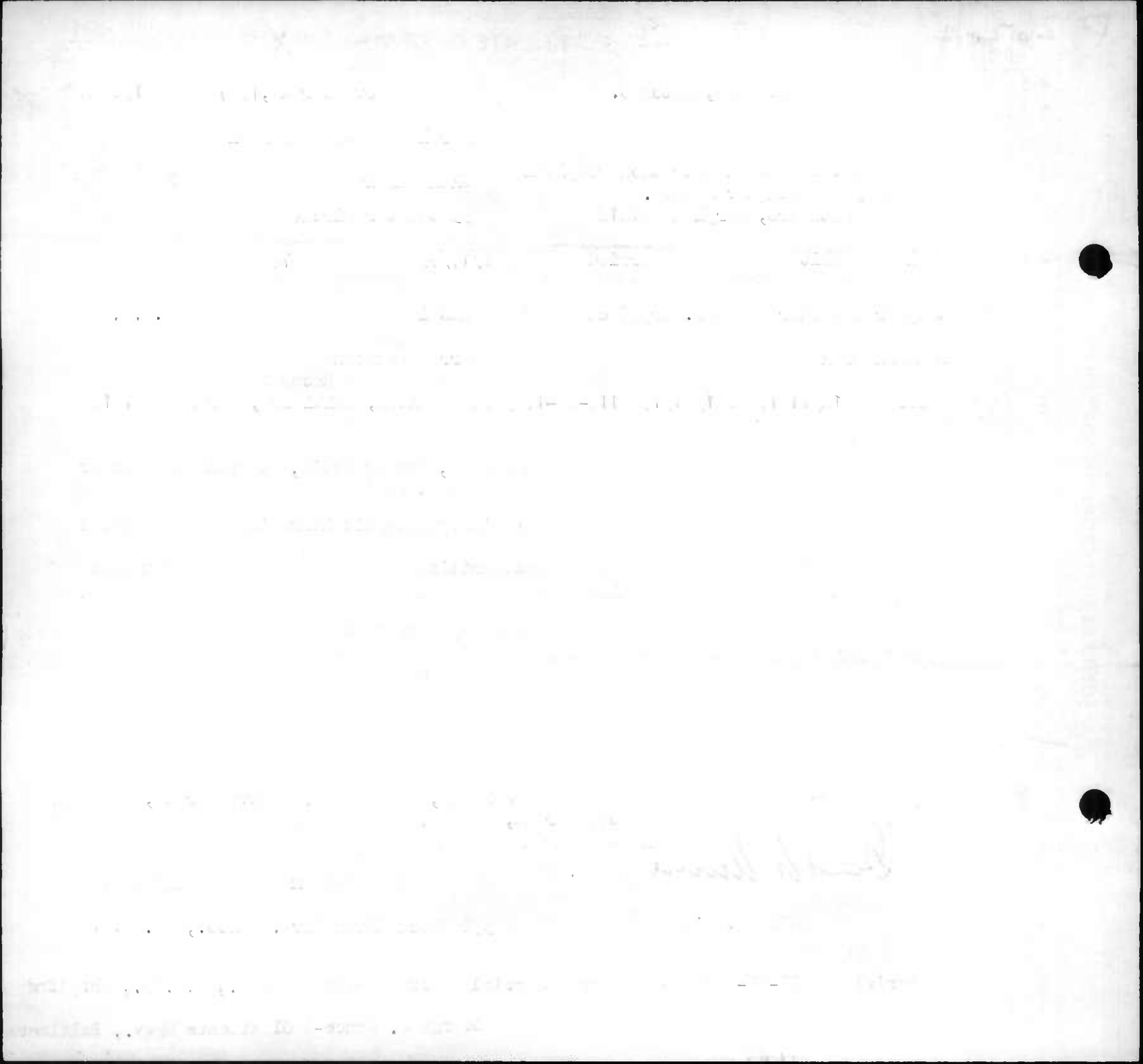
11-13-94  
11-13-94  
11-13-94

11-13-94

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11321		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11321	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PISARUK, Anton C.			
2. DATE AND HOUR OF DEATH November 22, 1967		150 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 27 Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218		A. STATE Maryland B. COUNTY Anne Arundel C. CITY OR TOWN (If outside city limits, write RURAL and give township) Glen Burnie D. STREET ADDRESS (If rural, give location) 33 Chester Circle			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6/17/93	9. AGE (In years last birthday) 74	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chipper & Corker		10B. KIND OF BUSINESS OR INDUSTRY Md. Dry Dock		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Paul Pisaruk		14. MOTHER'S MAIDEN NAME Warra Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 12/11/17 to 1/21/19		16. SOCIAL SECURITY NO. PN116-06-1793		17. INFORMANT Records ADDRESS VA Hospital, Baltimore, Maryland 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 002,11+204.0		CAUSE OF DEATH (A) Pulmonary, Tuberculosis, Moderately Advanced, Active (B) Chronic Lymphocytic Leukemia (C) Pneumonitis		INTERVAL BETWEEN ONSET AND DEATH years years few days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary Emphysema			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work [ ] Not While At Work [ ]	
21F. HOW DID INJURY OCCUR?		22. I certify that (X) (this hospital) attended the deceased from July 25, 19 67 to November 22, 19 67, that (X) (we) last saw the deceased alive on November 22, 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.		23A. SIGNATURE [Signature] M.D. Attending Phys. [ ] Med. Director [ ] Staff Phys. [X]	
23B. DATE SIGNED 11/22/67		23C. PHYSICIAN'S NAME (Type) DAVID N. MARINE		23D. ADDRESS M.D. 3900 Loch Raven Blvd. Balto., Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-25-1967		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park	
24D. LOCATION Ritchie Hwy., A.A.Co., Maryland		25A. DATE RECEIVED BY HEALTH DEPT. NOV 27 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hwy., Baltimore					





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>67 11322</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>67 11322</b>	
1. NAME OF DECEASED (Type or Print) <b>Bertie S. Miller</b>			2. DATE AND HOUR OF DEATH <b>11/20/67 6:25 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>48 Maryland General Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 27-15</b> D. STREET ADDRESS (If rural, give location) <b>2211 W. Rogers Ave.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>5/1/1890</b>	9. AGE (In years last birthday) <b>77 YRS.</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Silas Pomeroy</b>			14. MOTHER'S MAIDEN NAME <b>Martha A. Lohew</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-24-6435</b>	17. INFORMANT ADDRESS <b>Methodist Home</b>		
18. <b>500 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Acute bronchitis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examination) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>November 5, 1967</b> to <b>November 20, 1967</b> , that (I) (we) last saw the deceased alive on <b>November 20, 1967</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William L. Boddie</b> M.D.			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)
23D. ADDRESS M.D.			23E. FUNERAL DIRECTOR ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/24/67</b>		24C. NAME of CEMETERY or CREMATORY <b>ST. JOHN'S CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>ELLICOTT CITY, MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Wm. J. Tichner &amp; Son Baltimore</b>			

1874  
The following  
are the names of  
the persons who  
were present at  
the meeting of  
the 11th of  
the month of  
the year 1874.

1. John Smith  
2. John Doe  
3. John Roe  
4. John Brown  
5. John Black  
6. John White  
7. John Grey  
8. John Green  
9. John Gold  
10. John Silver

1874  
The following  
are the names of  
the persons who  
were present at  
the meeting of  
the 11th of  
the month of  
the year 1874.

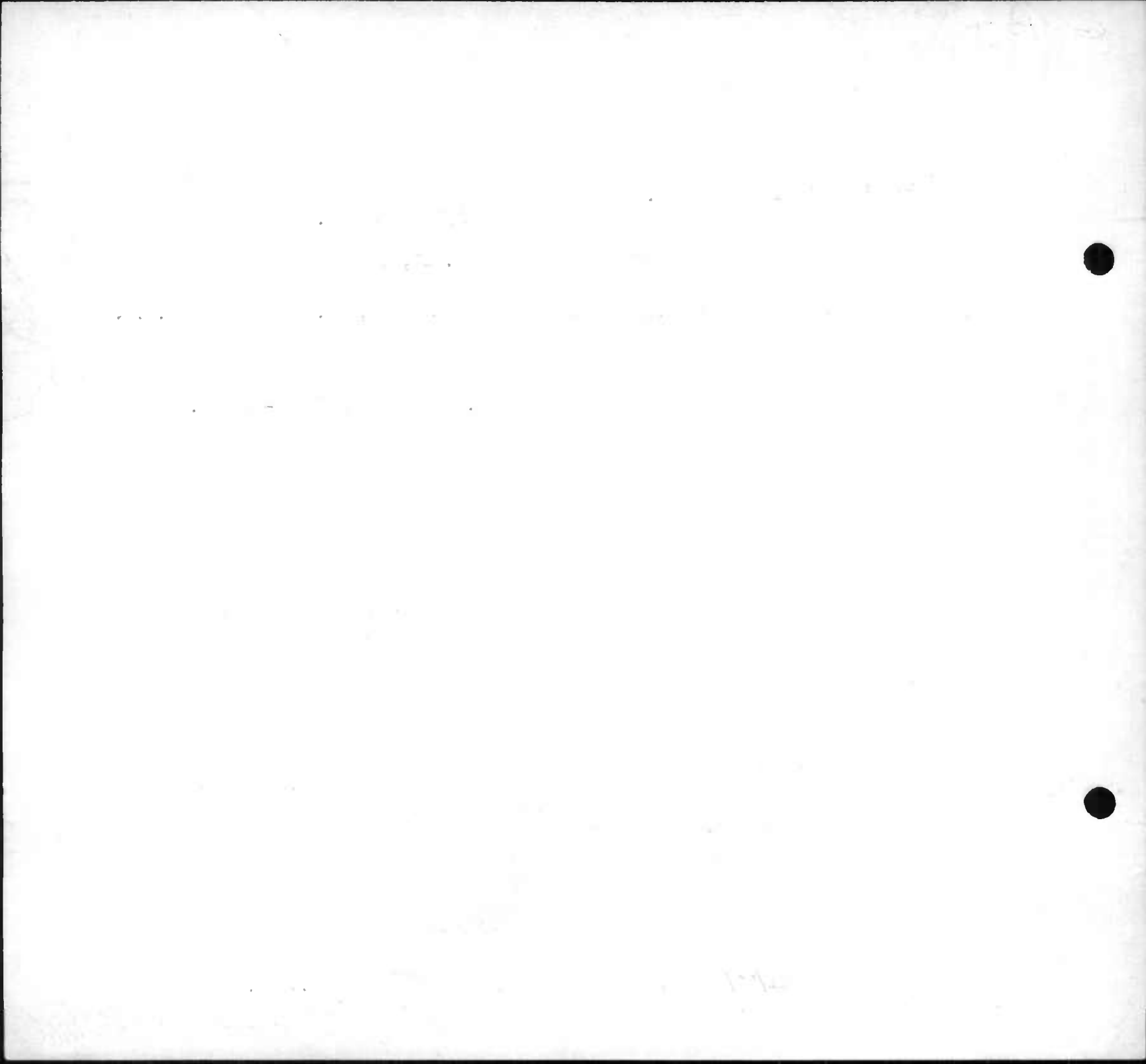
1. John Smith  
2. John Doe  
3. John Roe  
4. John Brown  
5. John Black  
6. John White  
7. John Grey  
8. John Green  
9. John Gold  
10. John Silver

1874  
The following  
are the names of  
the persons who  
were present at  
the meeting of  
the 11th of  
the month of  
the year 1874.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 11323					Registered No. 67 11323				
CERTIFICATE OF DEATH									
BIRTH NO. M.E. CASE NO.					2. DATE AND HOUR OF DEATH 11/19/67 7 P M.				
1. NAME OF DECEASED (Type or Print) <b>JESSE GOLDSMITH</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>90 KENESAW NURSING HOME 2601 ROSLYN AVE.</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>4305 RIDGE RD.</b>				
5. SEX <b>MALE</b>	6. RACE <b>CAU</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>OCT. 10, 1890</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STOCK CLERK</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>AMERICAN WHOLESALE</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>JOSEPH GOLDSMITH</b>					14. MOTHER'S MAIDEN NAME <b>LINDA FULD</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>MR. CHARLES GOLDSMITH- 300 W. ARUNDEL RD.</b>				
18. <b>154X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <i>Carcinomatous</i> (A) DUE TO <i>Prostatic Cancer</i> (B) DUE TO (C)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Arterio-sclerosis L.V.</i> <i>Diabetic Sensitivity</i>					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>Nov. 1967</i> to <i>Nov 19 1967</i> , that (I) (we) last saw the deceased alive on <i>Nov. 19 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Michael Byrally</i> M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>11/21/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Michael Byrally</i>					23D. ADDRESS M.D. <i>5320 York Rd</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/22/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>CEDAR HILL CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO., MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>		25B. NAME OF REGISTRAR <i>Robert E. Fisher M.D.</i>			25C. FUNERAL DIRECTOR <i>Wm. J. Tichner Sons Balto. Md.</i>			ADDRESS	



5-600

67 11324 BALTIMORE CITY HEALTH DEPARTMENT

67 11324

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)  
RENZY

SAWYER

2. DATE AND HOUR PRONOUNCED DEAD

November 18, 1967 9:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6905 Windsor Mill Road

5. SEX

Male

6. RACE

White

7. MARRIED, ~~NEVER MARRIED~~  
~~WIDOWED, DIVORCED~~ (Specify)

MARRIED

8. DATE OF BIRTH

JUNE 19, 1912

9. AGE (In years last birthday)

55

If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SUB\*CONTRACTOR

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

CRESTWELL, N.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

RENZY SAWYER

14. MOTHER'S MAIDEN NAME

CALLIE DAVENPORT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

21207

MRS. JAMES SAWYER 6905 WINDSOR MILL RD

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic and hypertensive cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/19/67

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

11/22/67

23C. NAME OF CEMETERY OR CREMATORY

WOODLAWN CEMETERY

23D. LOCATION

(City, town, or county)

(State)

WOODLAWN, MD.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Wm. J. T. ...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11325		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11325	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Rosa Fezner		11/17/67 11:30 A.M.	
M.E. CASE NO.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3927 Belle Ave. Balto., Md.		A. STATE Md. B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15-10	
				D. STREET ADDRESS (If rural, give location) 3927 Belle Ave.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
F.	White	Widowed	9/7/1891	76	Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		—		Balto., Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Louis Tachum			Rosa Held		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Howard Fezner - 3927 Belle Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422.1 I		(A) Myocardial Infarction			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		DUE TO			
ANTECEDENT CAUSES		(B) Anterior Myocardial Infarction -			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO			
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 1958 to November 17, 1967, that (I) (we) last saw the deceased alive on November 17, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Cecil Rudner					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Cecil Rudner				6821 Reisterstown Road 2125	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		11/20/67		Loudon PK.	
				Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 27 1967		Robert E. Tachum		Cecil J. Tachum - Son - Balto., Md.	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11326</b>	
67 11326				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		ANNA WARFIELD		2. DATE AND HOUR OF DEATH 11/17/67 10 <sup>15</sup> P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO 27-15	
18 Md. GENERAL HOSPITAL				D. STREET ADDRESS (If rural, give location) 2211 W. ROGERS AVE. 21209	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12/09/85	9. AGE (In years last birthday) 81	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Md. BALTO.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM HIDEY		14. MOTHER'S MAIDEN NAME MARGARET SMITH	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212283769-A		17. INFORMANT ADDRESS WESLEY HOFFE 2211 W. ROGERS AVE.	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Diffuse cerebral arteriosclerosis (B) DUE TO (C) (Basilar artery insufficiency) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 3 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/14 19 67 to 11/17 19 67 that (I) (we) last saw the deceased alive on 11/17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. N. RAVRIDIS				23B. DATE SIGNED 11/17/67	
23C. PHYSICIAN'S NAME (Type) A. N. RAVRIDIS		23D. ADDRESS Md. GENERAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/21/67		24C. NAME OF CEMETERY or CREMATORY MT. OLIVE CEMETERY	
24D. LOCATION (City, town, or county) (State) RANDALLSTOWN, MD.		25A. DATE REC'D BY HEALTH DEPT. NOV 27 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Wm. J. McKenney		25D. ADDRESS 2121 17			



67 11327

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11327

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WALTER McCANN

2. DATE AND HOUR PRONOUNCED DEAD

November 19, 1967 11:10 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

2129 N. Calvert St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2129 N. Calvert St.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

6-22-1902

9. AGE (In years  
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Paper Hanger

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Richmond, Va.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

220-67-3859

17. INFORMANT

ADDRESS

Judy Harman - 3508 Louth Rd.

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular  
DUE TO

Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 20, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/22/67

23C. NAME OF CEMETERY or CREMATORY

Loudon Pk. Cem

23D. LOCATION

(City, town, or county)

(State)

Balto, Md.

24A. DATE REC'D BY HEALTH DEPT.

NOV 27 1967

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

Wm. J. Tichner &amp; Sons Balto, Md.

ADDRESS



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11328

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EDWARD KILLEN

2. DATE AND HOUR PRONOUNCED DEAD

November 16, 1967 3:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1040 Lerew Way

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

11/7/1922

9. AGE (in years  
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Princeton, W. Va.

12. CITIZEN OF  
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Edward Killen

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War II

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs. Linda Mumper - 2800 Yorkway

ADDRESS

Dundalk

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic heart disease

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 16, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

23B. DATE

11/18/67

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION, (City, town, or county) (State)

Princeton, W. Va.

24A. DATE REC'D BY HEALTH DEPT.

NOV 27 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Wm. J. Tichner &amp; Son - Balto, Md.

ADDRESS

4/7/1952

Overseas

Director, W.A.

Director

Edward Kille

Unknown

for further

for further information see page 1

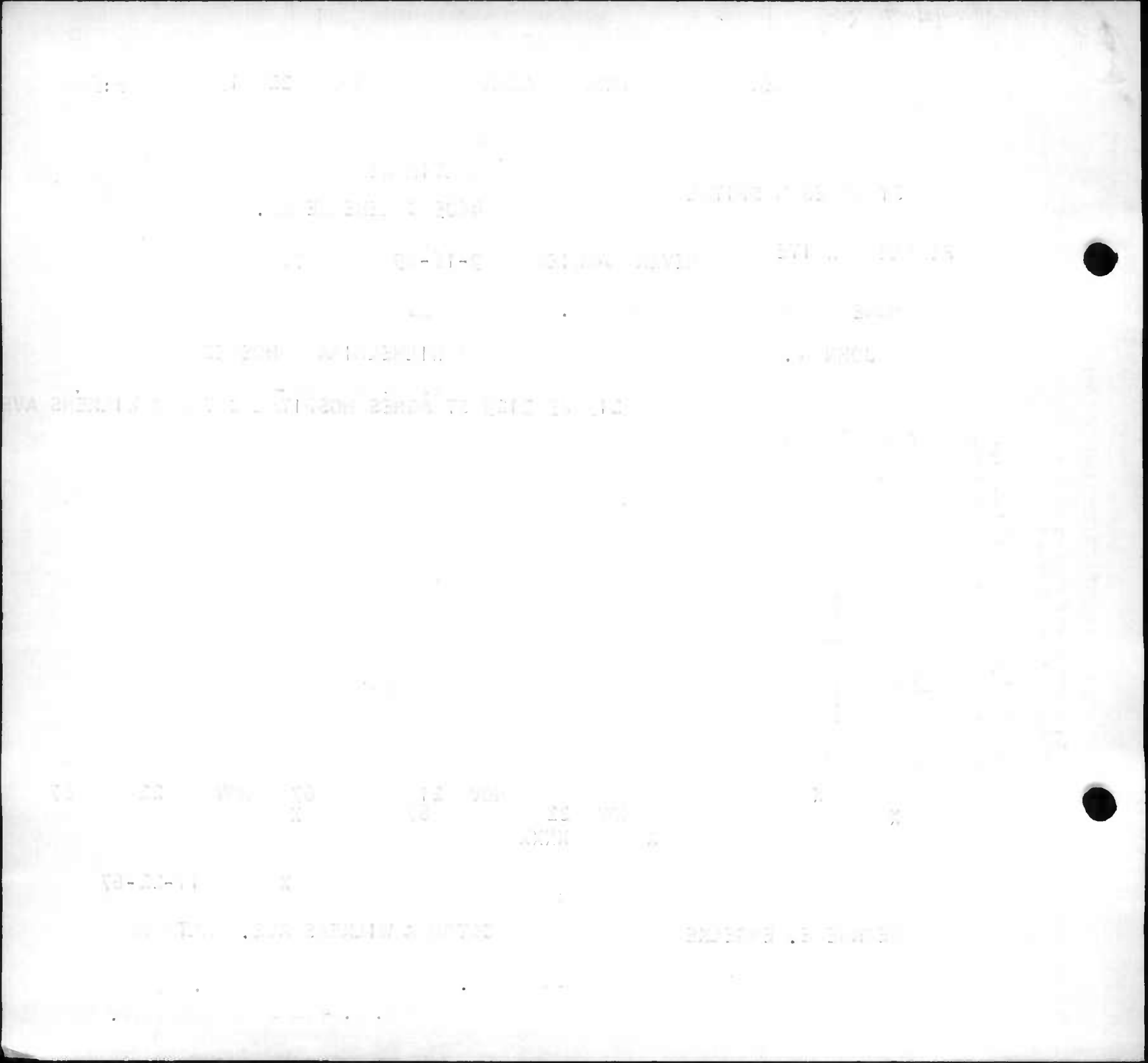
Received 11/1/52

Chief of Technical Services, W.A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 11329</b>	
BIRTH NO. <b>H-655</b>		67 11329 <b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>HERMANN NORA ANNA</b>		<b>NOV 22 1967 9:50A M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>40 ST AGNES HOSPITAL</b>		A. STATE <b>MD</b> B. COUNTY	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
		D. STREET ADDRESS (If rural, give location) <b>4605 COLEHERNE RD.</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>9-16-89</b>
		9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Stewart &amp; Co.</b>	11. BIRTHPLACE (State or foreign country) <b>MD</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOHN C. Hermann</b>	
14. MOTHER'S MAIDEN NAME <b>WILHELMINA HOENES</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>215 03 2129</b>		17. INFORMANT <b>Helen W. Hermann - 4605 Coleherne Rd.</b>	
18. <b>175.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of ovary 2 1/2 yrs</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>NOV 21 1967</b> to <b>NOV 22 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>NOV 22 1967</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <b>XXXX</b> view the body after death.			
23A. SIGNATURE <b>George E. Engelke</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>11-22-67</b>
23C. PHYSICIAN'S NAME (Type) <b>GEORGE E. ENGELKE</b> M.D.			23D. ADDRESS <b>CATON &amp; WILKENS AVE. BALTO MD</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>11/25/67</b>	24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>	25B. NAME OF REGISTRAR <b>George E. Engelke</b>	25C. FUNERAL DIRECTOR <b>Witzke F. D. - 4101 Edmondson Ave.</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-320		67 11330		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11330	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>MRS. FREDA M. LOTZ</i>			
2. DATE AND HOUR OF DEATH <i>11-24-67 5:10 AM</i>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>34 BON SECOURS HOSP. FAYETTE &amp; PULASKI STS.</i>		III not in hospital or institution, give street address or location)		A. STATE <i>MARYLAND</i>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, give RURAL and give township) <i>BALTIMORE 2706</i>			
				D. STREET ADDRESS (If rural, give location) <i>5502 PILGRIM ROAD</i>			
5. SEX <i>F</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>6/23/82</i>	9. AGE (In years last birthday) <i>85</i>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>WM - VOLKERT</i>				14. MOTHER'S MAIDEN NAME <i>EMMA SCHAEFFER</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>V. Grace Lingg-5502 Pilgrim Rd. PTS. CHART</i>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Chronic Arteriosclerotic Cardiovascular disease</i>				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Cerebral Thrombosis</i>							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Gangrene on the Rt leg.</i>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>10/24/67</i> to <i>11-24/67</i> , that (I) (we) last saw the deceased alive on <i>11/24/67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Yong Cho</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>11-24-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>YONG CHO</i>				23D. ADDRESS <i>Bon Secours Hosp. 205 W. Fayette St.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/27/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>Nov 27 1967</i>		25B. NAME OF REGISTRAR <i>R. E. E. Jr.</i>		25C. FUNERAL DIRECTOR <i>Witzke F. D. - 4101 Edmondson Ave.</i>		ADDRESS	

1911

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>67 11331</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>67 11331</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		Registered No. <span style="border: 1px solid black; padding: 2px;">X</span>	
BIRTH NO. <span style="font-size: 1.5em;">452</span> M.E. CASE NO.		2. DATE AND HOUR OF DEATH November 24, 1967 <span style="font-size: 1.5em;">12</span> <span style="font-size: 1.5em;">30</span> P.M.	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Noma Hendrix Williams</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore Co</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">5021 West Hills Rd.</span> <span style="font-size: 1.5em;">LUTHERAN HOSPITAL</span> <span style="font-size: 1.5em;">(D.O.A.)</span>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">5021 West Hills Rd.</span>	
5. SEX <span style="font-size: 1.2em;">FEMALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Divorced</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">5/30/99</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Balto., Md.</span>	9. AGE (In years last birthday) <span style="font-size: 1.5em;">68</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">Late - Purdy</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">212-25-8922</span>	
17. INFORMANT <span style="font-size: 1.2em;">Mr. Jack Hendrix</span> <span style="font-size: 1.2em;">4017 McDowell Lane - 21227</span>		ADDRESS	
18. <span style="font-size: 1.5em;">331X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Cerebral hemorrhage</span>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">10 minutes</span>		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">6/13</span> 19 <span style="font-size: 1.2em;">66</span> to <span style="font-size: 1.2em;">11/24</span> 19 <span style="font-size: 1.2em;">67</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">10/25</span> 19 <span style="font-size: 1.2em;">67</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <span style="font-size: 1.2em;">did</span> (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.5em;">Robert A. Reiter</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">11/25/67</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Robert A. Reiter</span>		23D. ADDRESS <span style="font-size: 1.2em;">606 Edmondson Ave. 21228</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">11/28/67</span>	
24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Crest Lawn Cem.</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">NOV 27 1967</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Farley, M.D.</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Witzke F. D. - 4101 Edmondson Ave.</span>		ADDRESS	

Subject to approval of medical examiner

James M. Smith

1871

James M. Smith

James M. Smith

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11332		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11332	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Daisy Blackwell</i>		2. DATE AND HOUR OF DEATH <i>November 24, 67 12:32 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>9-08</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>THE UNION MEMORIAL HOSPITAL</i> <i>44 33rd + CALVERT ST.</i> <i>BALTIMORE, MARYLAND 21218</i>		D. STREET ADDRESS (If rural, give location) <i>505 E 23rd St</i>			
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>8/10/91</i>	9. AGE (In years last birthday) <i>76</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>UNEMPLOYED</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>not known</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME <i>not known</i>		14. MOTHER'S MAIDEN NAME <i>not known</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Louise Ruth (daughter)</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>422.11</i>		CAUSE OF DEATH (A) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (B) DUE TO (C) DUE TO		ADDRESS <i>505 E 23rd St</i> INTERVAL BETWEEN ONSET AND DEATH <i>about 18 mo</i>	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <i>November 27, 1967</i> to <i>November 29, 1967</i> , that (we) last saw the deceased alive on <i>November 27, 1967</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>William H. Jencer - Strong</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>November 28, 1967</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/28/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>St. Calvary Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>A.A. County Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 27 1967</i>			
25B. NAME OF REGISTRAR <i>Robert S. Taylor</i>		25C. FUNERAL DIRECTOR <i>Adolphus Halstead</i>			
25D. ADDRESS <i>1206 W North Ave.</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11333		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 67 11333	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>MOODY, MRS HANNAH</b>			2. DATE AND HOUR OF DEATH <b>11/25/67 1230 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>RUTH</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GEN'L HOSP 48</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO. 17-01</b>		
D. STREET ADDRESS (If rural, give location) <b>828 DRUID HILL AVE</b>					
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>?</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LAUNDRY WORKER LAUNDRY</b>			11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>UNK. ) Jene</b>			14. MOTHER'S MAIDEN NAME <b>UNK. ) Lillian Harris</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>0</b>		17. INFORMANT (FRIEND) ADDRESS <b>Mrs Anna Johnson Same</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) <b>E 9/6/0</b>			CAUSE OF DEATH (A) DUE TO <b>85% 3° Thermal BURNS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs.</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION lost.			(B) DUE TO		(C)
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>HOME</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>828 DRUID HILL AVE</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>NOV. 24 67 9PM</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>CLOTHING CAUGHT FIRE FROM SPACE HEATER</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>10-24</b> 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>10-25</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Frank J. Zorick</b> M.D.			23B. DATE SIGNED <b>11-25-67</b>		
23C. PHYSICIAN'S NAME (Type) <b>FRANK J. ZORICK</b> M.D.			23D. ADDRESS <b>MARYLAND GENERAL HOSP</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>B</b>	24B. DATE <b>11/28/67</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cemetry</b>		24D. LOCATION (City, town, or county) (State) <b>A A County Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>		25B. NAME OF REGISTRAR <b>John E. Talley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>1141 E. 9th St</b>	

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J-250		67 11334		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11334	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) GRACE E. JACKSON				2. DATE AND HOUR PRONOUNCED DEAD November 19, 1967 5:55 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1669 W. North Avenue				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1669 W. North Avenue			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Jan. 25, 1911	9. AGE (In years last birthday) 56	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Carter				14. MOTHER'S MAIDEN NAME Lillian Curry			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Agnes Jones 2931 Clifton Avenue			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 11/19/67							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 11-22-67		23C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk.		23D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24A. DATE REC'D BY HEALTH DEPT. NOV 27 1967		24B. NAME OF REGISTRAR Robert E. Jackson		24C. FUNERAL DIRECTOR ADDRESS Arlington S. Phillips 1727 N. Monroe St.			

WALLS & FLOORS

PAINTING

PAINTING

100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 11335</u>	
BIRTH NO. <u>67 11335</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>JAMES CLEVELAND STONE</u>		2. DATE AND HOUR OF DEATH <u>November 23, 1967 2:10 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>1010 ST. DUNSTAN ROAD</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>2/22/30</u>	9. AGE (In years last birthday) <u>37</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CANNER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Mass Union Metal, Chelsea</u>		11. BIRTHPLACE (State or foreign country) <u>MASSACHUSETTS</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CLEVELAND STONE</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Deasy</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>034-20-8242</u>		17. INFORMANT <u>Chelsea Mass. Frank A. Welsh &amp; Sons Funeral Home</u>	
18. <u>393.71</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cerebellar Abscess &amp; Encephalitis</u> <u>Chronic Rt. Mastoiditis</u> <u>10 days</u> <u>1 month</u>		CAUSE OF DEATH (A) <u>Bronchopneumonia</u> DUE TO (B) <u>Cerebellar Abscess &amp; Encephalitis</u> DUE TO (C) <u>Chronic Rt. Mastoiditis</u> DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 days</u> <u>1 month</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>November 15, 1967</u> to <u>November 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>November 23, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>November 23, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>MIGUEL SANCHEZ PALACIOS</u>		23D. ADDRESS M.D. <u>UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>11/27/67</u>	24C. NAME of CEMETERY or CREMATORY <u>Woodlawn</u>		24D. LOCATION (City, town, or county) (State) <u>EVERETT Chelsea, Mass.</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Inc. Baltimore, Md. 21202</u>	

NOV 27 1967

UNION MEMORIAL HOSPITAL  
1010 ST. JAMES ROAD  
BOSTON, MASS.

W. M. BAKER  
MASSACHUSETTS  
CLEVELAND, OHIO

24

November 12, 1913  
November 12, 1913

W. M. BAKER  
UNION MEMORIAL HOSPITAL  


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

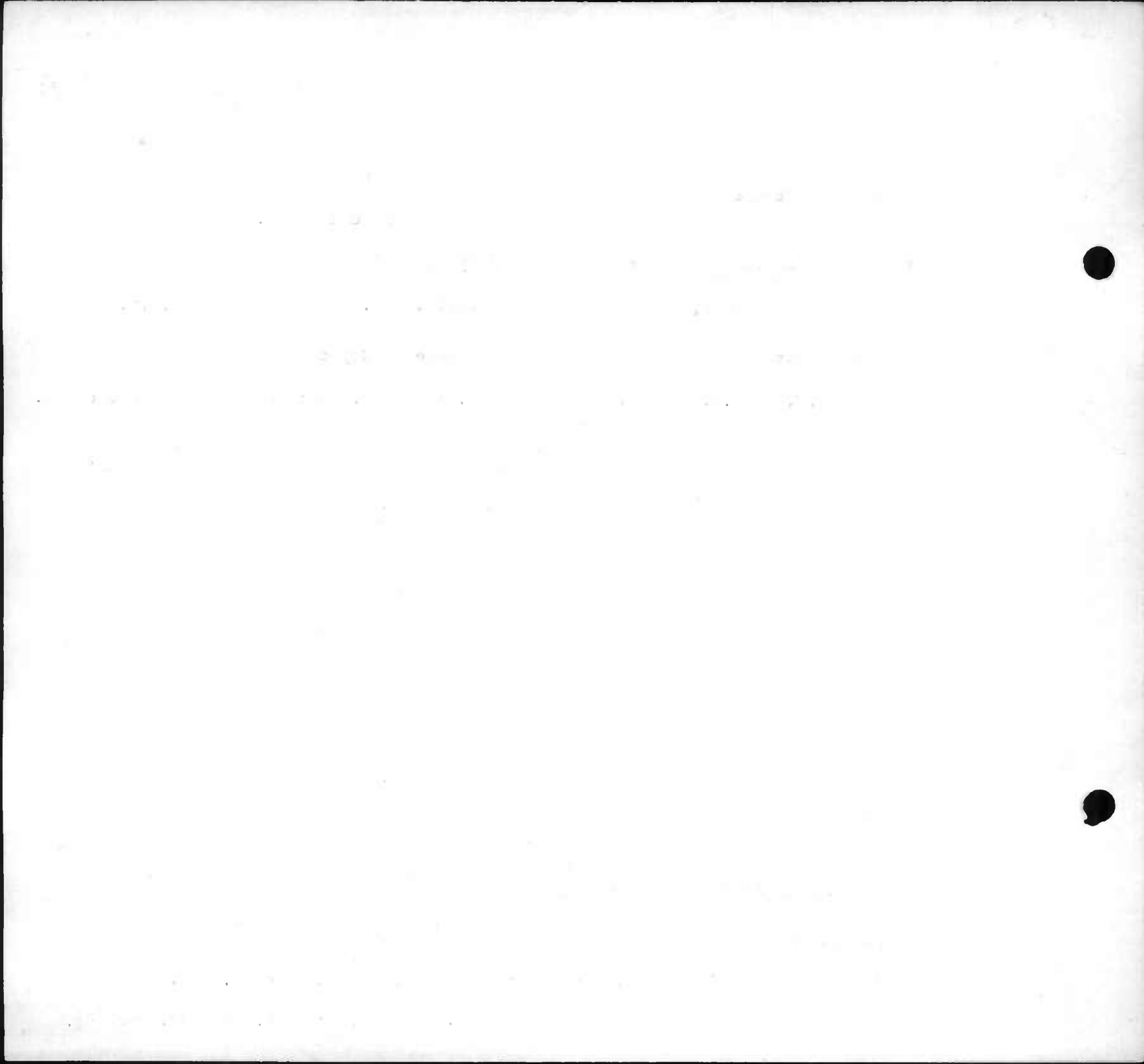
BIRTH NO. 67 11336		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11336	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Mary Alverta Schlueter			2. DATE AND HOUR OF DEATH Nov. 23, 1967 10:15 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balt C		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital 3100 Wyman Pk. Drive			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00		
D. STREET ADDRESS (If rural, give location) 6005 Hunt Ridge Rd.					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10/22/94	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph Waltemyer			14. MOTHER'S MAIDEN NAME Keziah Royston		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-32-7021	17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pulmonary embolus (A) DUE TO			INTERVAL BETWEEN ONSET AND DEATH Minutes		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Mycosis fungoides (B) DUE TO			Years		
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute bronchial pneumonia, left lung			Days		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Oct. 31 19 67 to Nov. 23 19 67, that (I) (we) last saw the deceased alive on Nov. 23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William L. Willie M.D.			23B. DATE SIGNED 11/24/67		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) Wm. L. Willie, Surgeon (R)			23D. ADDRESS US PHS Hospital, Balto, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment	24B. DATE 11-27-67	24C. NAME OF CEMETERY or CREMATORY Lorraine Park Mausoleum	24D. LOCATION (City, town, or county) (State) Woodlawn Maryland		
25A. DATE REC'D BY HEALTH DEPT. NOV 27 1967	25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson Inc 1050 York Rd. Towson, Md. 21204		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">67 11337</span>	
BIRTH NO. <span style="float: right;">67 11337</span>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		FRANCIS LEROY WINTER		11/25/67 8:30 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  1316 Windemere Ave 21218			A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1316 Windemere Ave.		
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH July 30, 1896	9. AGE (In years last birthday) 71	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroads
11. BIRTHPLACE (State or foreign country) Balto., Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Winter			14. MOTHER'S MAIDEN NAME Cecelia Snyder		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.I & W.W.II		16. SOCIAL SECURITY NO. 705-05-6634		17. INFORMANT ADDRESS Mr. Edward W. Schellhas 1316 Windemere Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CAUSE OF DEATH (A) Cardiac decompensation (B) A.S.C.V.D. (C) _____ INTERVAL BETWEEN ONSET AND DEATH 3 da 2 yr		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Emphysema, severe 10 yr.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Apr 6 1966 to Nov 25 1967, that (I) <del>was</del> last saw the deceased alive on Nov 24 1967 and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>not</del> view the body after death.					
23A. SIGNATURE Thomas R. Freeman Jr.				23B. DATE SIGNED 11/27/67	
23C. PHYSICIAN'S NAME (Type) M.R. FREEMAN JR.		23D. ADDRESS 11 W. 29th St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/27/67		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 27 1967		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc. 1217 St. Paul St.	

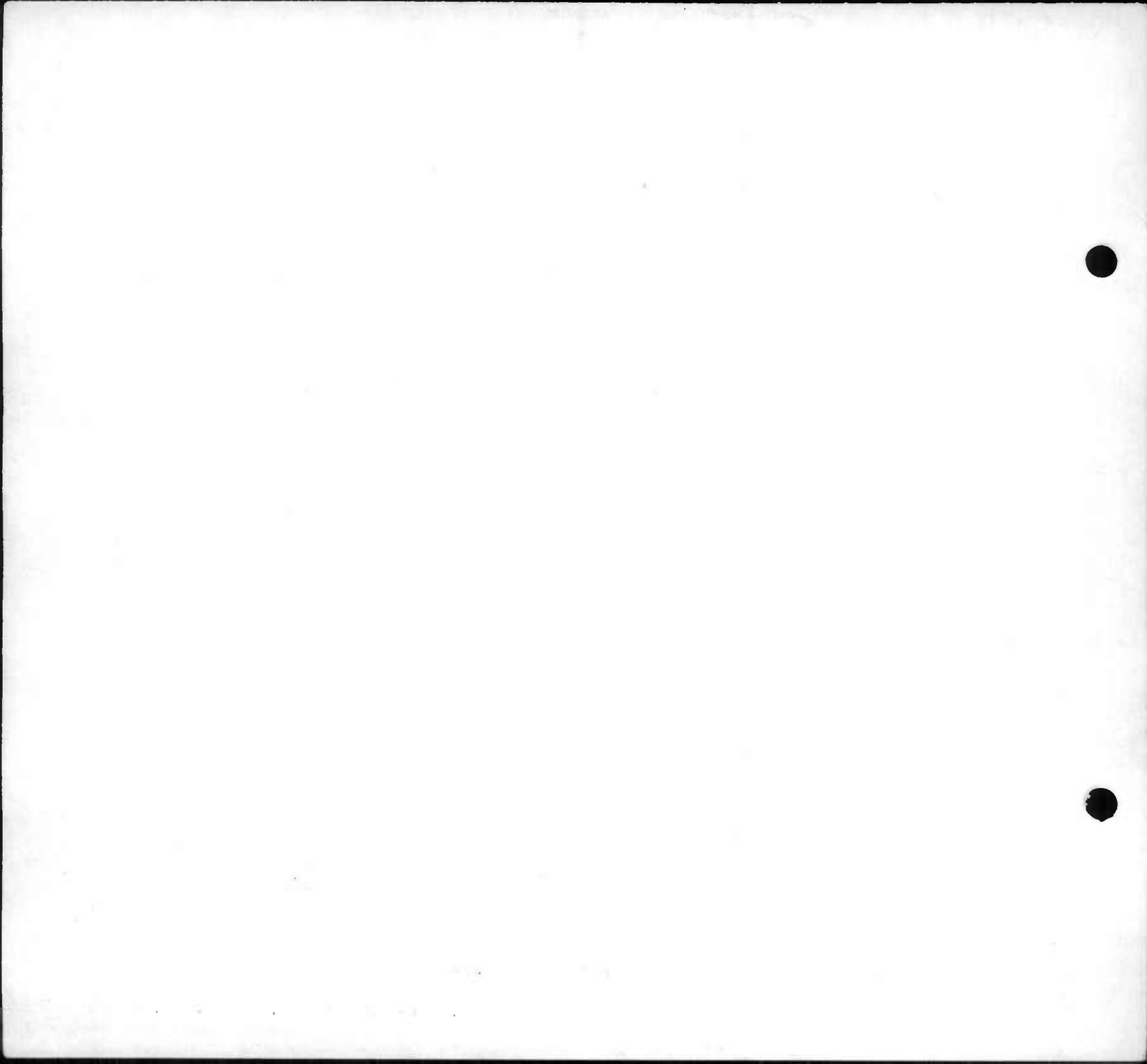




FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11338</b>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <b>67 11338</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
<div style="display: flex; justify-content: space-between;"> <span>M.E. CASE NO.</span> <span>1. NAME OF DECEASED (Type or Print) <b>PAGE EDW. BROWNE</b></span> <span>2. DATE AND HOUR OF DEATH <b>11/24/67 4:05 P.M.</b></span> </div>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Md. GENERAL HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution's residence before admission) A. STATE <b>Md.</b> B. COUNTY _____		
5. SEX <b>M.</b> 6. RACE <b>W.</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>			8. DATE OF BIRTH <b>8/31/10</b> 9. AGE (In years last birthday) <b>57</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHIPPER</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>ANDERSON and IRELAND INCORP.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>EDW. T. BROWN</b>		
14. MOTHER'S MAIDEN NAME <b>EVA M. PEGLOW</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) _____		
16. SOCIAL SECURITY NO. <b>212-09-8076</b>			17. INFORMANT <b>FRANCES BROWN (wife)</b> ADDRESS <b>SAME.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Shock</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cardiac arrest</b> <b>Myocardial infarction (Asteroid)</b>			INTERVAL BETWEEN ONSET AND DEATH <b>55 min.</b>		
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <b>11/24 1967</b> to <b>11/24 1967</b> , that (I) (we) last saw the deceased alive on <b>11/24 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>A. N. Mauridis</b> M.D.				23B. DATE SIGNED <b>11/24/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>A. N. Mauridis</b>				23D. ADDRESS <b>Md. GENERAL HOSP.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/27/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Prospect Hill Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Towson, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. [unclear]</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Inc. Balto. Md. 21202</b> ADDRESS _____	



E-1521

67 11339

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

67 11339

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES HENRY EVANS

2. DATE AND HOUR OF DEATH

11-19-67 5:40 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

38 UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

2038 W. HAYETTE ST.

5. SEX

MALE WHITE

6. RACE

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SEPARATED

8. DATE OF BIRTH

March 24, 1906 61

9. AGE (in years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

NONE

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIAM H. EVANS

14. MOTHER'S MAIDEN NAME

ELIZABETH ROCKRELL

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

NONE

16. SOCIAL  
SECURITY NO.

NONE

17. INFORMANT

ADDRESS

MRS. EVANS, 2040 W. HAYETTE ST.

18. 581.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) Liver Failure &amp; Hepatic Encephalopathy 1 month

(B) Laennec's Cirrhosis years?

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Urinary tract infection

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At  
Work ☐Not White  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-20 1967 to 11-19 1967,  
that (I) (we) last saw the deceased alive on 11-19 1967 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending  
Phys. ☐Med.  
Director ☐Stoll  
Phys. ☒

23B. DATE SIGNED

11-19-67

23C. PHYSICIAN'S  
NAME (Type)

M.D.

23D. ADDRESS

UNIVERSITY HOSP - BALT., MD

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial 11-25-67

London PARK

BALTIMORE, MD

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

NOV 27 1967

Robert E. Farley, Jr.

GEO. L. SCHWAB FUNERAL HOME  
Francis H. Miller 2101 Frederick Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Mr. J. H. ...  
at 38 N. ...  
place white separated

1/24 ...  
William H. ...  
place

James ...

...

...

...

...

...

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-236		67 11340		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11340	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Foster Edward</i>				11/24/67 8:55 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital of Baltimore</i>		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY Baltimore Co	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Lutherville 53-00			
				D. STREET ADDRESS (If rural, give location) Box 97, Route 1, Falls Road			
5. SEX Male	6. RACE Cau.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Sept. 4, 1907	9. AGE (In years last birthday) 60 Years	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice-President		10B. KIND OF BUSINESS OR INDUSTRY Bendix Corp.		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eleazark Foster				14. MOTHER'S MAIDEN NAME Eugenia Noyes			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 101-05-9084		17. INFORMANT ADDRESS Mrs. Patricia M. Foster, Same as # 4	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) 420, 114260X CAUSE OF DEATH (A) <i>Acute MI</i> DUE TO (B) <i>ASCVD</i> DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i> <i>unknown</i>							
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes Mellitus</i>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Oct 14</i> 19 <i>67</i> to <i>Nov 12</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Kenneth Wetcher</i> M.D.				23B. DATE SIGNED 11/24/67		23C. PHYSICIAN'S NAME (Type) KENNETH WETCHER M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE Nov. 27, 1967		24C. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Gardens		24D. LOCATION (City, town, or county) (State) Cockeysville, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 27 1967		25B. NAME OF REGISTRAR <i>R. E. Edwards</i>		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson,		ADDRESS 1050 York Road Towson, Maryland	

London

Oct 17, 1917, 1918, 1919, 1920

Oct 17, 1917, 1918, 1919, 1920

Oct 17, 1917, 1918, 1919, 1920

Oct 17, 1917, 1918, 1919, 1920

Oct 17, 1917, 1918, 1919, 1920

Oct 17, 1917, 1918, 1919, 1920

Oct 17, 1917, 1918, 1919, 1920

L-400

67 11341

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 11341

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HOWARD

F.

LILLEY

LILLY Sr.

2. DATE AND HOUR PRONOUNCED DEAD

November 23, 1967 11:35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Church Home and Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1927 E. Lombard St.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec. 25, 1892

9. AGE (In years  
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Fred Gross &amp; Sons

11. BIRTHPLACE (State or foreign country)

Wilmington, Delaware

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Albert M. Lilley

14. MOTHER'S MAIDEN NAME

Clara

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

213-05-9706

17. INFORMANT

Mrs. Ida Lilley 1927 E. Lombard Street

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/24/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11-28-1967

23C. NAME OF CEMETERY or CREMATORY

Lake View

23D. LOCATION

(City, town, or county)

Carroll County, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.

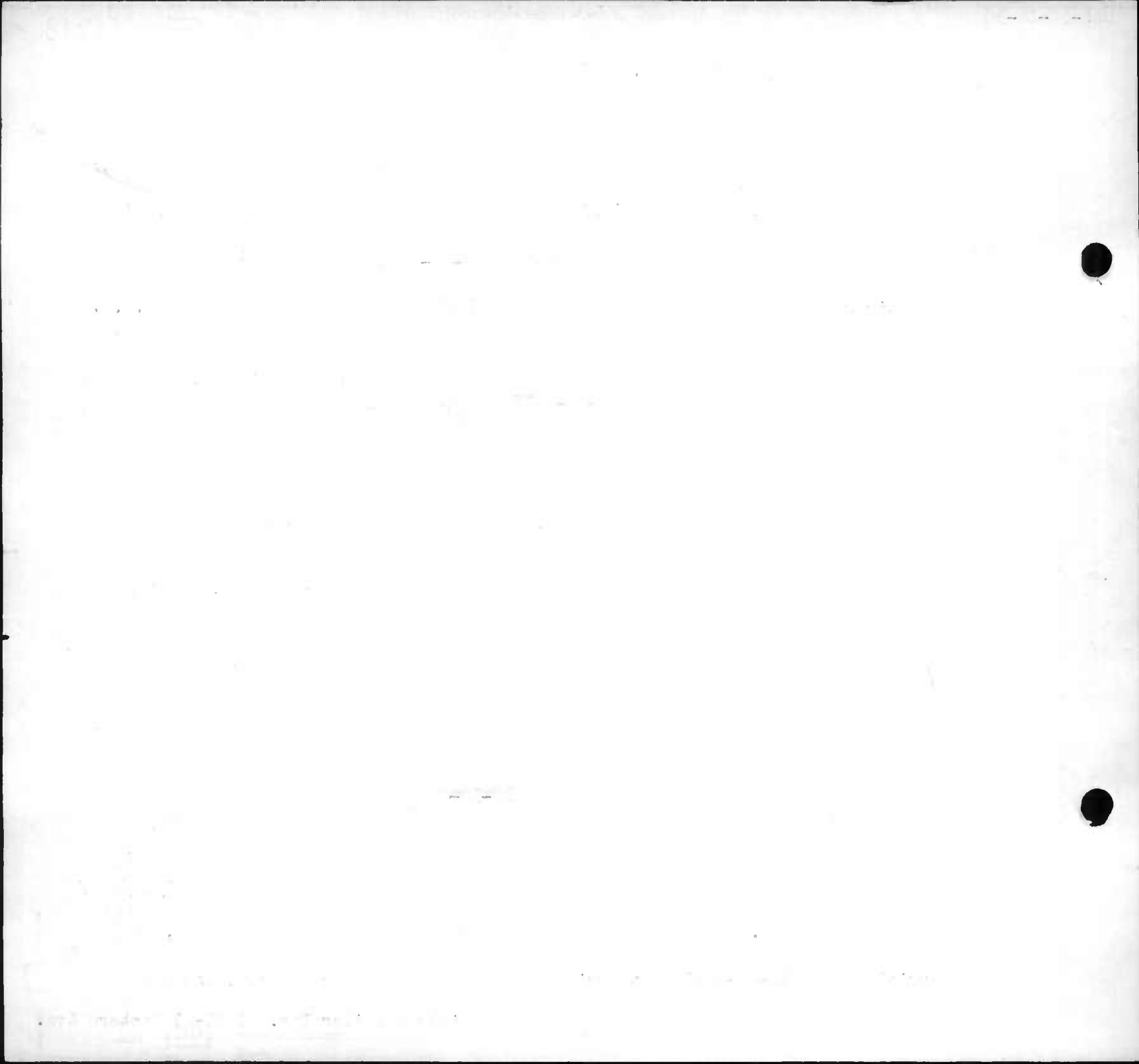
LONGER



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>G-621</b>		67 11342		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 11342</b>	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>GEORGE W. CRISP</b>		2. DATE AND HOUR OF DEATH <b>11/24/67</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>		C. CITY OR TOWN (If outside city limits, write RURA and give township) <b>Baltimore</b>		D. STREET ADDRESS (If rural, give location) <b>3311 East Pratt Street</b> <b>21224</b>		E. AGE (in years last birthday) <b>66</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Never Married</b>	8. DATE OF BIRTH <b>8-29-1901</b>	9. AGE (in years last birthday) <b>66</b>	10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10. B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph</b>		14. MOTHER'S MAIDEN NAME <b>Margaret</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>220-05-1177</b>		17. INFORMANT <b>Records: BCH-4940 Eastern Avenue</b>		ADDRESS <b>21224</b>		18. CAUSE OF DEATH <b>Urinary Tract Infection</b> <b>Benign Prostatic Hypertrophy</b> <b>CVA 2° arteriosclerotic Cardiovascular disease</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Urinary Tract Infection</b>		20. INTERVAL BETWEEN ONSET AND DEATH <b>1 mon</b>		21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Diabetes</b>		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
23. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>11/17/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Benign Prostatic Hypertrophy</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>10-30-1967</b> to <b>11-24-1967</b> and that (I) (we) last saw the deceased alive on <b>11-24-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>David E. McBeth</b>	
23B. PHYSICIAN'S NAME (Type) <b>David E. McBeth</b>		23C. ADDRESS <b>4940 Eastern Avenue, Baltimore, Maryland</b>		23D. DATE SIGNED <b>11/24/1967</b>		23E. MED. DIRECTOR <input type="checkbox"/> Med. Director <input type="checkbox"/> Still Phys. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-28-1967</b>		24C. NAME of CEMETERY or CREMATORY <b>Meadowridge</b>		24D. LOCATION (City, town, or county) (State) <b>Howard County, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc.</b>		ADDRESS <b>1901-07 Eastern Ave.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

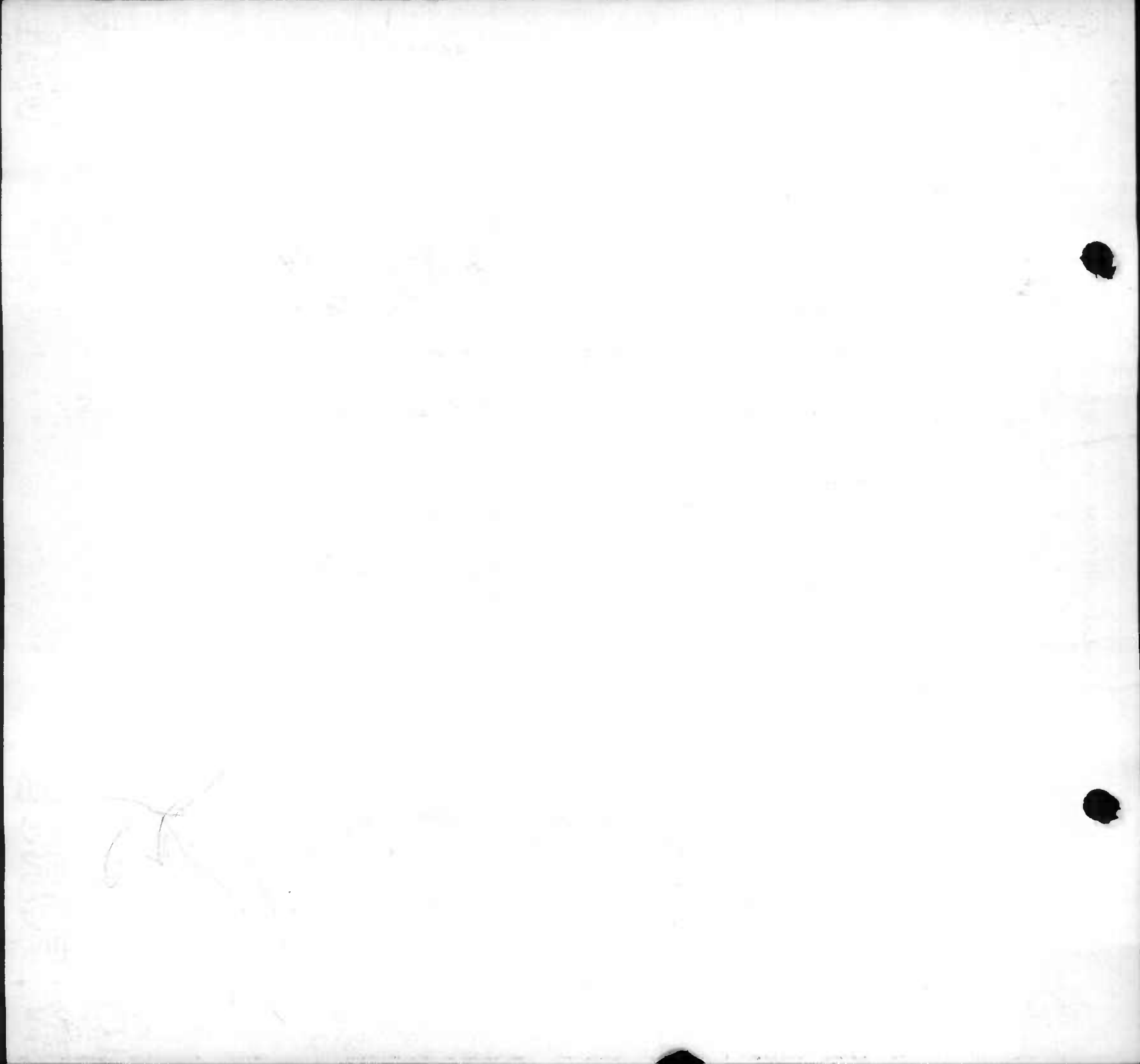
F-450 1		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11343	
67 11343		BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <b>JOSEPH G. FLYNN</b>			2. DATE AND HOUR OF DEATH <b>November 24, 1967</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>31 Baltimore City Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>245 S. East Avenue</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify) Married</b>	8. DATE OF BIRTH <b>April 27, 1896</b>	9. AGE (In years lost birthday) <b>71</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Wood Calker</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Arundel Corp.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <b>Patrick H. Flynn</b>		
14. MOTHER'S MAIDEN NAME <b>Elizabeth Lightner</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>214-01-2115</b>			17. INFORMANT ADDRESS <b>Mrs. Mathilda Flynn 245 S. East Avenue</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>420.1 I</b> <b>CORONARY THROMBOSIS</b> INTERVAL BETWEEN ONSET AND DEATH <b>INSTANTANEOUS</b>			19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CORONARY ARTERY DISEASE UNKNOWN.</b>		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b> <b>GENERALIZED ARTERIOSCLEROSIS UNKNOWN</b>					
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No) <b>No</b>	
21D. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21G. TIME OF INJURY (Month) (Day) (Year) (Hour)		21H. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21I. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/18</b> 19 <b>67</b> to <b>11/24</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11/11</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Henry J. Housha</b>				23B. DATE SIGNED <b>11/27/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>HENRY J. HOUSHA</b>				23D. ADDRESS <b>333 S. EAST AVE BALTO-MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-28-1967</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.</b>			



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				67 11344		67 11344	
BIRTH NO.				M.E. CASE NO.		Registered No.	
1. NAME OF DECEASED (Type or Print) <b>ABRAHAM D. GOLDEN</b>				2. DATE AND HOUR OF DEATH <b>11-24-67 12:40 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>LUTHERAN HOSPITAL OF MARYLAND 730 ASHBURTON ST. BALTIMORE, MD 21216</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 16-07</b> D. STREET ADDRESS (If rural, give location) <b>3000 BAKER ST.</b>			
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>2-14-13</b>	9. AGE (In years last birthday) <b>54</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>North Carolina</b>		11. PLACE OF BIRTH (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Lee Golden</b>			14. MOTHER'S MAIDEN NAME <b>Carrie Colvin</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>090-10-1603</b>		17. INFORMANT <b>Edna Golden - 3000 Baker St.</b>		ADDRESS	
18. <b>443X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>CARDIOVASCULAR ACCIDENT</b> DUE TO (B) <b>HYPERTENSION</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11-22-1967</b> to <b>11-24-1967</b> , that (I) (we) last saw the deceased alive on <b>11-24-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>S. Aziz</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-24-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>S. AZIZ</b>				23D. ADDRESS <b>LUTHERAN HOSP of MD. 730 ASHBURTON ST. BALTIMORE MD 21216</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-29-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisk</b>		25C. FUNERAL DIRECTOR <b>Jurnell B. Oden - Balto. Md.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">67 11345</span>	
67 11345				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Williams, Jennie</u>				11/25/67 5:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hosp. of Balto.</u>		A. STATE <u>Md.</u>		B. COUNTY	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		<u>BALTO.</u>	
		D. STREET ADDRESS (If rural, give location)		<u>1602</u> <u>1020 Whatcoat Street</u>	
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>8/25/10</u>	9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>GA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Hall</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>David Williams</u>	
				ADDRESS <u>SAME</u>	
18. <u>445 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>CO<sub>2</sub> Narcosis</u> DUE TO <u>Chronic Lung Disease superimposed</u> (B) <u>a pneumonia</u> DUE TO (C) <u>malignant hypertension &amp; nephrosclerosis</u> (D) <u>Stroke</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>November 17, 1967</u> to <u>November 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>November 25, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ( <u>did</u> ) ( <u>did not</u> ) view the body after death.					
23A. SIGNATURE <u>Myung Sun Yoon</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11/29/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem. Pk.</u>	
24D. LOCATION (City, town, or county) (State) <u>Arbutus, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 27 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>	
25C. FUNERAL DIRECTOR <u>Nelson Funeral Home</u>		25D. ADDRESS <u>1348 Calhoun St.</u>			

2/2/12  
100

James Ward & Co  
London

James Ward & Co  
London

James Ward & Co  
London

James Ward & Co  
London



5-435

67 11346

BALTIMORE CITY HEALTH DEPARTMENT

67 11346

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MELVIN

SELDON

2. DATE AND HOUR PRONOUNCED DEAD

November 23, 1967 | 8:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Lutheran Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

825 Mt. Holly Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

7/9/48

9. AGE (In years  
last birthday)

19

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ind.

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Melvin

14. MOTHER'S MAIDEN NAME

Doris Seldon

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Sarah Seldon

ADDRESS

same

18. E812.4 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Multiple Traumatic Injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Fulton and Lohrman Sts.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
11/23/67 8:25 P.m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by car

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/24/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/27/67

23C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cem.

23D. LOCATION

(City, town, or county)

(State)

Baets, Ind.

24A. DATE RECD BY HEALTH DEPT.

NOV 27 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Kilox Funeral Home 1348 Calhoun St.

ADDRESS

WILLIAM BOINGE

WILLIAM BOINGE

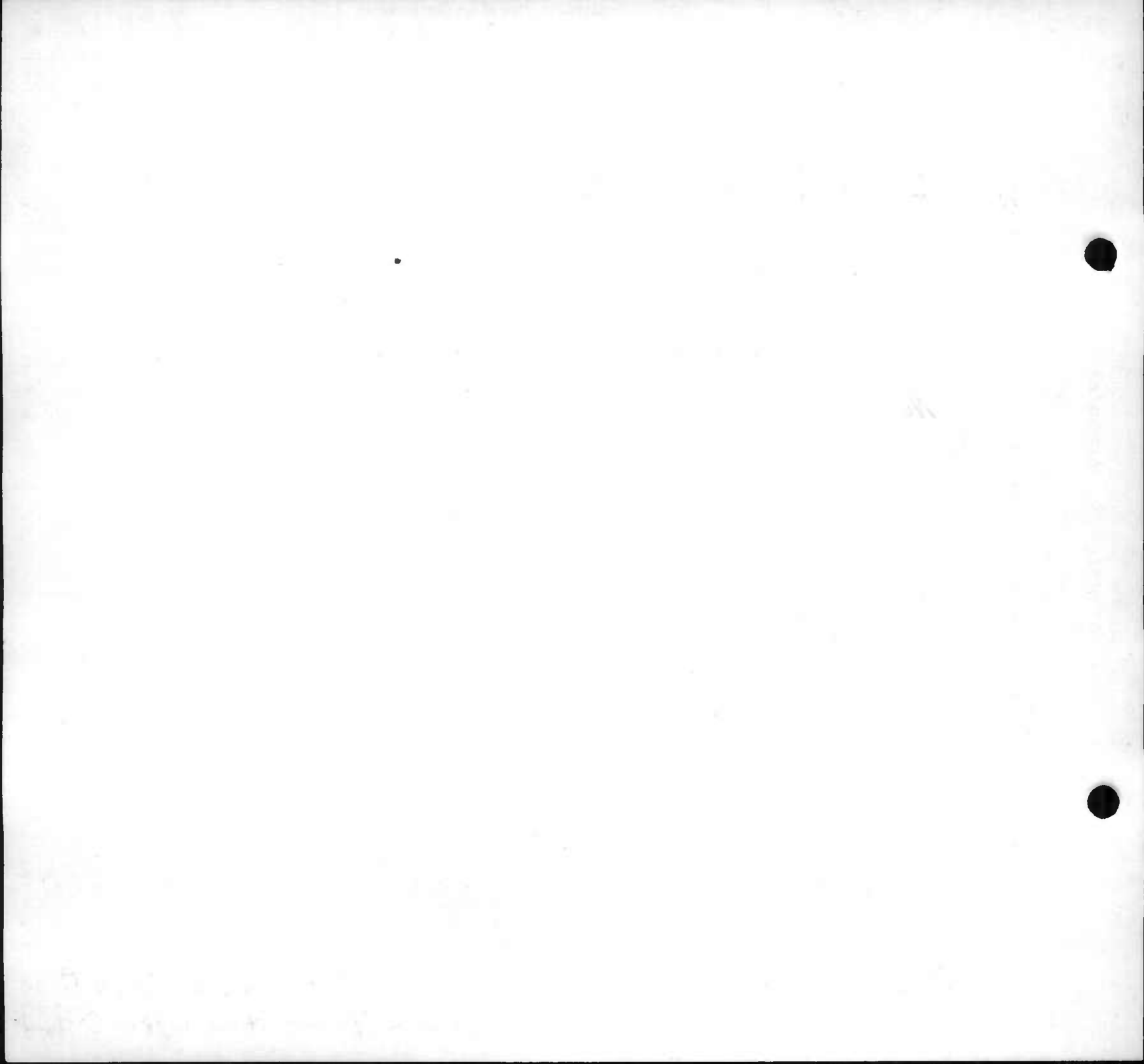
WILLIAM BOINGE

WILLIAM BOINGE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 11347				67 11347		67 11347	
M.E. CASE NO.				1. NAME OF DECEASED			
(Type or Print)				Susan D. THORNTON			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				2. DATE AND HOUR OF DEATH			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
002501 Woodland Ave				Md. Baltimore			
				C. CITY OR TOWN (If outside city limits, give RURAL and give township)			
				Baltimore 27-16			
				D. STREET ADDRESS (If rural, give location)			
				2501 Woodlane Ave.; Baltimore 21215			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
F	C	W	1871	96			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					Gloucester, Va.		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William Dean				Patsy Dingen			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		220-54-5287		Mrs. Thelma J. Evans		2501 Woodlane Ave Baltimore, 21215	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
				Acute Pulmonary Edema 1/2 hour			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				HASCVD Many Years			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
D				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from September 19 66 to November 19 67, that (1) (we) lost saw the deceased alive on Sept. 10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Jose ARDAIZ						November 25, 67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Jose ARDAIZ				M.D. 7 OBERLIN COURT, Towson, Md. 21204			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		11/28/67		Zion Church		Gloucester Co, VA	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			
NOV 27 1967		Robert E. Farley		Kelson Funeral Home 1348 N. Calhoun			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-640		67 11348		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11348	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>BURRELL, Rudolph McKinley</b>				2. DATE AND HOUR OF DEATH <b>November 21, 1967 10:40 P M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital</b> <b>3900 Loch Raven Blvd.</b> <b>Baltimore, Maryland 21218</b>				A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>				D. STREET ADDRESS (If rural, give location) <b>2174 Hollins Street</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify) Married</b>	8. DATE OF BIRTH <b>5/15/06</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brakeman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>West Point, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Burrell</b>				14. MOTHER'S MAIDEN NAME <b>Marion Tyree</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1/20/44 to 11/7/45</b>		16. SOCIAL SECURITY NO. <b>220-07-2993</b>		17. INFORMANT <b>Records</b>		ADDRESS <b>V.A. Hosp. Baltimore, Md. 21218</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Bronchogenic Carcinoma</b> DUE TO (A) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) _____ (C) _____				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from <b>October 10, 1967</b> to <b>November 21, 1967</b> , that (X) (we) last saw the deceased alive on <b>November 21, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Romney D.</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>November 22, 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>Romney D.</b>				23D. ADDRESS <b>3900 Loch Raven Blvd., Balto., Md. 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>II-27-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Ct</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore-City</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkley</b>		25C. FUNERAL DIRECTOR <b>Isaiah L. Brown and Son</b>		ADDRESS <b>108 W. Montgomery Street</b>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## CERTIFICATE OF DEATH

Registered No.

67 11349

BIRTH NO.

67 11349

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Anna Hopkins

2. DATE AND HOUR OF DEATH

November 25 1967 8:55 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS

(If rural, give location)

3307 Noble Street 21224

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

12-8-1890

9. AGE (In years  
last birthday)

76

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

August Styne

14. MOTHER'S MAIDEN NAME

Pauline

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18. ~~18. CAUSE OF DEATH~~

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) DUE TO

Carcinoma of Breast

(B) DUE TO

Metastasis to Lung

(C) DUE TO

Respiratory Arrest

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Rheumatoid Arthritis

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/25 19 67 to 11/25/67 19 67,  
that (I) (we) last saw the deceased alive on 11/25 19 67 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Joel Thurn

M.D.

Attending  
Phys. ☐Med.  
Director ☐Stoll  
Phys. ☒

23B. DATE SIGNED

11/25/67

23C. PHYSICIAN'S  
NAME (Type)

JOEL THURN

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

25D. NAME OF REGISTRAR

25E. NAME OF REGISTRAR

25F. NAME OF REGISTRAR

25G. NAME OF REGISTRAR

25H. NAME OF REGISTRAR

25I. NAME OF REGISTRAR

25J. NAME OF REGISTRAR

25K. NAME OF REGISTRAR

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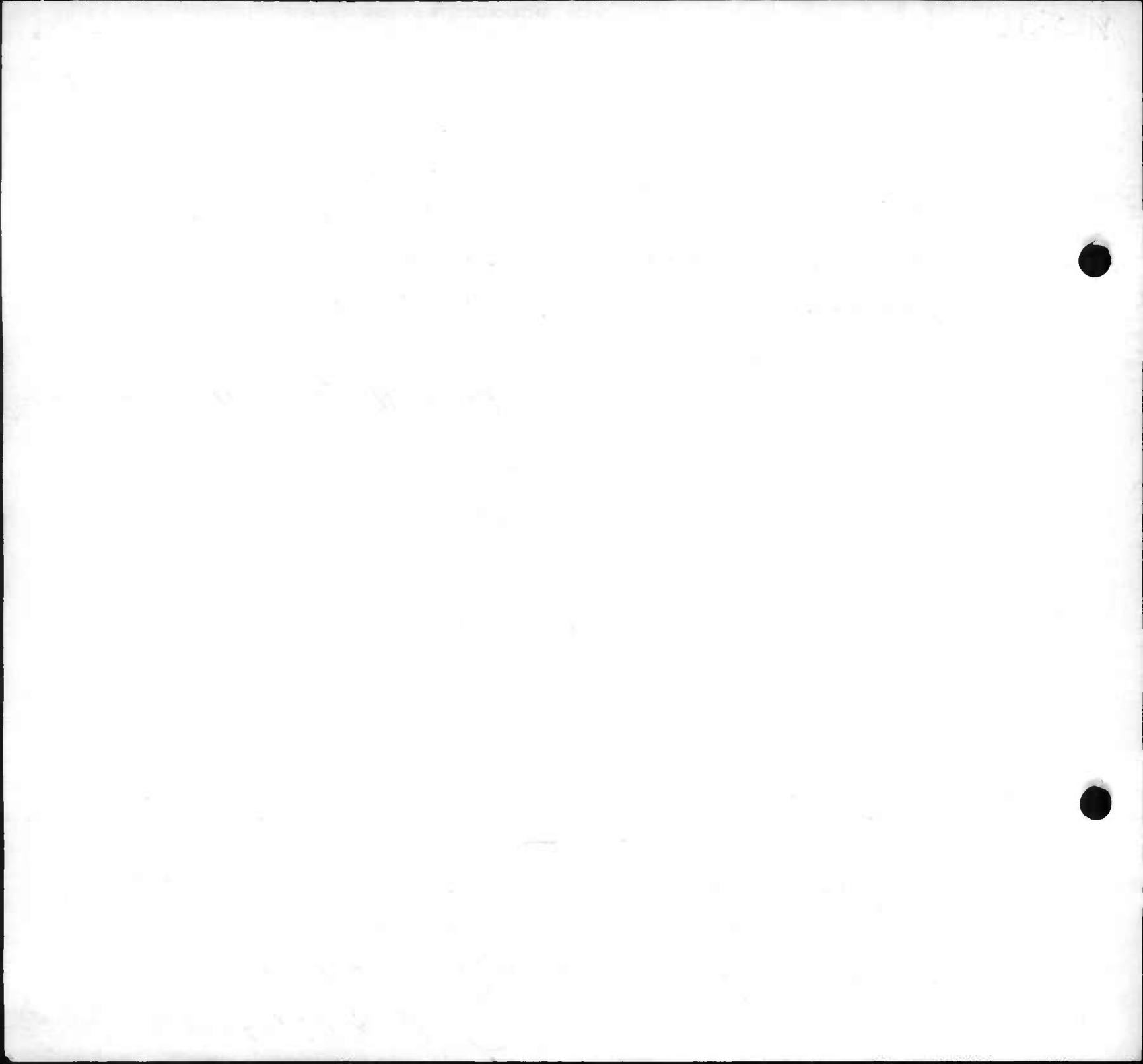
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 67 11350					CERTIFICATE OF DEATH					Registered No. 67 11350				
1. NAME OF DECEASED (Type or Print) <b>VICTOR MONTERIO</b>					2. DATE AND HOUR OF DEATH <b>11/25/67 1 30P</b>					M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>9-08</b>									
FULL NAME OF HOSPITAL OR INSTITUTION <b>1010 E. North AVE</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO. MD</b>									
					D. STREET ADDRESS (If rural, give location) <b>1010 E. North Ave</b>									
5. SEX <b>M</b>		6. RACE <b>C</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>6-12-02</b>		9. AGE (In years last birthday) <b>65</b>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMAN</b>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <b>PORTUGAL</b>				
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME <b>?</b>					14. MOTHER'S MAIDEN NAME <b>?</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT <b>ROXIE MONTERIO 1010 E. North AVE</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>443X-174X</b>					CAUSE OF DEATH (A) <b>CARDIOVASCULAR Disease</b> DUE TO (B) <b>CARCINOMA of MOUTH</b> DUE TO (C) _____					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>HYPERTENSION</b>									
19A. DATE OF OPERATION <b>0</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?					22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>JANUARY 4 1966</b> to <b>NOVEMBER 25 1967</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>Sept. 16 1967</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>Was</del> ) (did) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <b>Jesse T. Holmes</b>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <b>11/27/67</b>				
23C. PHYSICIAN'S NAME (Type) <b>Jesse T. Holmes</b>					M.D. 23D. ADDRESS <b>508 E. North Ave.</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>					24B. DATE <b>11/29/67</b>					24C. NAME OF CEMETERY or CREMATORY <b>MT. CALVARY</b>				
24D. LOCATION (City, town, or county) (State) <b>A.A. County, MD</b>					25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>					25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>				
25C. FUNERAL DIRECTOR <b>Joseph J. Rock</b>					ADDRESS <b>1304 N. Central</b>									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11351		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 11351	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <u>Tolliver, Marion</u>		
2. DATE AND HOUR OF DEATH <u>11/25/67</u> <u>9 35 A</u> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>7-09</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>		
			D. STREET ADDRESS (If rural, give location) <u>1416 HARFORD AVE</u>		
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWER</u>	8. DATE OF BIRTH <u>1-12-91</u>	9. AGE (In years lost birthday) <u>76</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Egg Candler</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Poultry Co.</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>Sophia</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>217-01-5056</u>		17. INFORMANT <u>ESTHER HARRIS</u>
			ADDRESS <u>2318 GARRETT AVE</u>		
18. <u>4-20-11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>myocardial infarction</u>			CAUSE OF DEATH (A) DUE TO <u>terminal</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u>			(B) DUE TO <u>15 years</u>		
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Chronic bronchitis</u> <u>14 lung mass - benign tumor</u> <u>aneurysm</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <u>11/19</u> 19 <u>67</u> to <u>11/25</u> 19 <u>67</u> , that (I) <del>(the)</del> last saw the deceased alive on <u>11/25</u> 19 <u>67</u> and that in (my) <del>(an)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(the)</del> (did) <del>(the)</del> view the body after death.					
23A. SIGNATURE <u>Elizabeth H. Jansson</u>				23B. DATE SIGNED <u>11/25/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Elizabeth H. Jansson</u>				23D. ADDRESS M.D. <u>Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11/29/67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MT. CALVARY</u>	
24D. LOCATION (City, town, or county) (State) <u>A.A. COUNTY. Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 27 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Joseph B. Locks</u>	
				ADDRESS <u>13047 Central Ave</u>	

Ascid  
? Myocardial infarction

YES  
Chronic bronchitis, limited emphysema

Elizabeth H. Jensen  
Elizabeth H. Jensen

Johns Hopkins Hospital

11/22/41  
11/14/41  
11/22/41

T 656

67 11352

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11352

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>MILTON TURNER</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>November 24, 1967 8:35 A. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>35 Church Home Hospital (DOA)</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>3-01</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>225 S. Bethel St.</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Never Married</b>	8. DATE OF BIRTH <b>2/14/28</b>	9. AGE (In years last birthday) <b>39</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waiter</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Milton Turner</b>				14. MOTHER'S MAIDEN NAME <b>Edna Kelley</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes ww 11</b>		16. SOCIAL SECURITY NO. <b>216-24-9553</b>		17. INFORMANT ADDRESS <b>Jessup, Md. Edna Howard Cedar Ave.,</b>			
18. <b>292.6 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Sickle Cell Disease</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) DUE TO (B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>11/24/67</b>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>11/29/67</b>		23C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>		23D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		24C. FUNERAL DIRECTOR ADDRESS <b>Charles A. Rice 661 W. Barre St.</b>			

WALTER W. PROCTOR

230 BROADWAY

NEW YORK

67 11353

BALTIMORE CITY HEALTH DEPARTMENT

67 11353

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES YELDELL

2. DATE AND HOUR PRONOUNCED DEAD

November 22, 1967 10:58 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 1104 W. Fayette Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1104 W. Fayette Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

5-19-1923

9. AGE (In years  
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Disabled Veteran

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Samuel Yeldell

14. MOTHER'S MAIDEN NAME

Rachel L. Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give year or dates of service)

yes

W. W. 7

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Samuel Yeldell (Anna M.)

ADDRESS

18. 4 4 3 X 1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 23, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11-27-1967

23C. NAME OF CEMETERY or CREMATORY

St. Broadbrook

23D. LOCATION

St. Margarets Md

24A. DATE REC'D BY HEALTH DEPT.

NOV 27 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

William Reese, M.D.

ADDRESS

WILLY  
VALLEY  
FOUNDS  
PAPER



THE BODY OF RUSSELL PINNICK WAS RELEASED BY DR. LINTHICUM OF THE MEDICAL EXAMINERS OFFICE AS **FUNERAL DIRECTOR: IMPORTANT** NON RED CASE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-520		67 11354		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11354	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type in Print) RUSSELL PINNICK				11/25/67 1:15 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33				A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give town) BALTIMORE D. STREET ADDRESS (If rural, give location) 1206 N. CAROLINE STREET 21213			
5. SEX MALE	6. RACE NEGROID	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-1-31	9. AGE (In years last birthday) 36	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant Seaman			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME JOSEPH PINNICK			14. MOTHER'S MAIDEN NAME JOANNA WILLIAMS				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Gloria Pinnick 1206 N. Caroline St		ADDRESS
18. 322.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) CARDIAC ARREST DUE TO (B) CARDIOMYOPATHY DUE TO (C) ? heavy alcohol ingestion		INTERVAL BETWEEN ONSET AND DEATH 1/2 HR 3-6 MONTH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/24/67 to 11/25/67, that (I) (we) last saw the deceased alive on 11/25/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Harry K. Genant				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/25/67	
23C. PHYSICIAN'S NAME (Type) HARRY K. GENANT				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/29/67		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem Park		24D. LOCATION (City, town, or county) (State) Arbutus Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 27 1967		25B. NAME OF REGISTRAR G. E. E. E.		25C. FUNERAL DIRECTOR Joseph E. E. E.		ADDRESS 11297 Caroline St	

Richard L. Hanson

Mr.

Miss Lillian

From Miss Lillian  
June 1922

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11355

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIE

D.

BARNETT

2. DATE AND HOUR PRONOUNCED DEAD

November 23, 1967

8:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Johns Hopkins Hospital (DOA)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1637 Lansing Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Nov 25 / 1921

9. AGE (In years  
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Rayboro N.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

Yes

World War 2

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Evelyn Barnett 1637 Lansing Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic and Hypertensive  
Disease  
XXXXX Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME OF INJURY (APPROX.)  
(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/24/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/28/67

23C. NAME OF CEMETERY or CREMATORY

Bald. Natl Cem

23D. LOCATION (City, town, or county) (State)

5501 Frederick Ave Baltimore

24A. DATE REC'D BY HEALTH DEPT.

NOV 27 1967

24B. NAME OF REGISTRAR

R. E. Spitz

24C. FUNERAL DIRECTOR

Z. T. Elchman 1129 N. Calver St

ADDRESS

March 1902/1901 No. 1  
Baptist N.C.

unpublished

the manuscript

Baptist Church 1837/1838

copy of the manuscript

the manuscript is in the possession of the Baptist Church

the manuscript is in the possession of the Baptist Church

the manuscript is in the possession of the Baptist Church

the manuscript is in the possession of the Baptist Church

the manuscript is in the possession of the Baptist Church

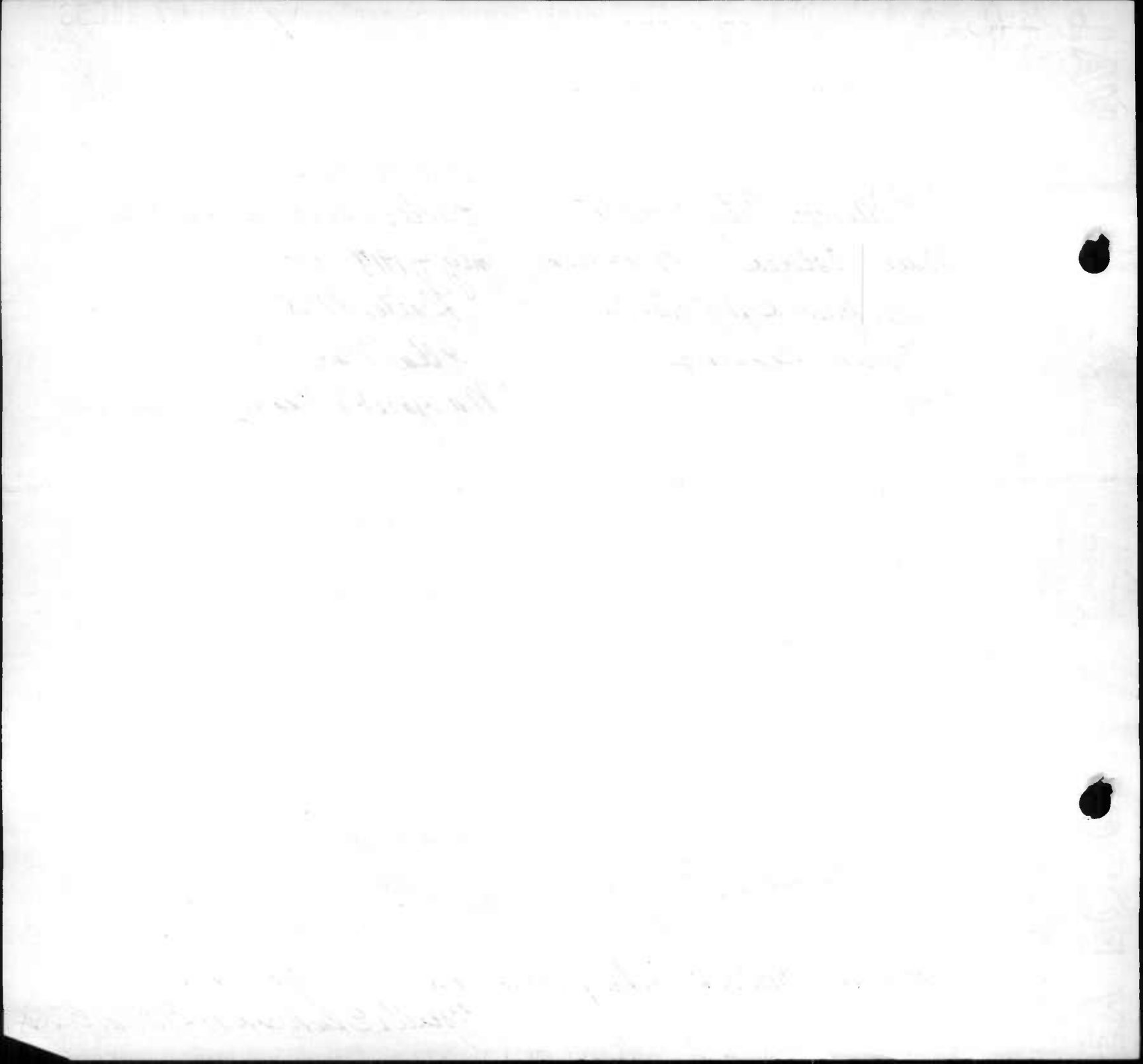
the manuscript is in the possession of the Baptist Church

From 11/20/01 to 11/20/02, the manuscript is in the possession of the Baptist Church

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 11356	
67 11356				67 11356	
BIRTH NO.				REGISTERED NO.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>Elmer G. Boasley</u>				2. DATE AND HOUR OF DEATH <u>November 23 1967</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospital</u>				A. STATE <u>MD</u> B. COUNTY <u>Balt. Co</u>	
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>53-00</u>	
5. SEX <u>Male</u> 6. RACE <u>Colored</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>				8. DATE OF BIRTH <u>July 4 1917</u> 9. AGE (In years last birthday) <u>50</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur Dept Motor Veh.</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>	
11. BIRTHPLACE (State or foreign country) <u>Bald. Md.</u>				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Louis Boasley</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Mae Boasley</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Margaret V. Boasley</u>				ADDRESS <u>Eastern Ave.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arterio Sclerosis</u>				<u>unknown</u>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>November 19 63</u> to <u>Nov. 23</u> 19 <u>67</u> , that (1) (we) lost saw the deceased alive on <u>November 7</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>David I. Miller</u> M.D.				23B. DATE SIGNED <u>11-26-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>David I. Miller</u> M.D.				23D. ADDRESS <u>Union Rd. Owings Mills, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Nov 26 67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Sharp Street Cem</u>	
24D. LOCATION <u>Chase Md.</u>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 27 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Frank E. Johnson 1129 N. Calhoun</u>	
25D. ADDRESS					



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11357 **CERTIFICATE OF DEATH** BALTIMORE CITY HEALTH DEPARTMENT

Registered No. 67 11357

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Mary E. Warrington (Warrenton)		November 22 1967 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE B. COUNTY			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
D. STREET ADDRESS (If rural, give location)				E. CITY OR TOWN (If outside city limits, write RURAL and give township)			
00 3511 Berwyn Ave.				3511 Berwyn Ave			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Female	Colored	married	Sept 22/1908	5-9	Housewife	Md.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Robert Proctor				Mary ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
						Francis Warrington (Warrenton)	
18. 5-92 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
				18 mo			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 1966 11/3 to 11/22 1967 and that (I) (we) last saw the deceased alive on 11/3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
F. J. Borges						11/26/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
FRANCIS J. BORGES				M.D. UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Nov 27/67		Mt Calvary Cem		A. A. County Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 27 1967		Robert E. Farber		Joseph P. Elckorn		1129 N. Calis	

25.1.1944  
District. District  
District. District

25.1.1944  
District. District  
District. District

25.1.1944  
District. District

25.1.1944  
District. District

25.1.1944  
District. District



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11358</b>
BIRTH NO. <b>67 11358</b>		<b>CERTIFICATE OF DEATH</b>		
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <b>Nov. 20, 1967</b>		
1. NAME OF DECEASED (Type or Print) <b>Alverta Parker</b>		M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Kenson Nursing Home</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3403 Woodbrook Ave.</b>		
5. SEX <b>Female</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>Sept. 30, 1878</b>	9. AGE (In years last birthday) <b>89</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Annapolis Maryland</b>
13. FATHER'S NAME <b>James Parker</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Agnes Rico, 3403 Woodbrook Ave.</b>
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Chronic Cardio-vascular Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Chronic Cardio-vascular Disease</b> DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Gangrene of right foot</b>		<b>Few days</b>		
19A. DATE OF OPERATION <b>NOA</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 21, 1967</b> to <b>Nov. 19, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 19, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Frank N. Ogden</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Nov. 25, 1967</b>
23C. PHYSICIAN'S NAME (Type) <b>FRANK N. OGDEN</b>		23D. ADDRESS M.D. <b>2701 N. Calvert St</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Nov. 25, 67</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>		
25B. NAME OF REGISTRAR <b>Chas. E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Charles R. Law, 802 Madison Ave.</b>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 11359</b>	
BIRTH NO. <b>67 11359</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>EVANS, SARAH J.</b>		2. DATE AND HOUR OF DEATH <b>11/25/67 2:10 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 THE JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>21215</b> D. STREET ADDRESS (If rural, give location) <b>2301 OCALA AVENUE</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>NEGROID</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>7-4-20</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OPERATOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>TELEPHONE CO.</b>	9. AGE (In years last birthday) <b>47</b>
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS EVANS JAMES</b>		14. MOTHER'S MAIDEN NAME <b>BERTHA BOYKIN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-18-5404</b>	
17. INFORMANT <b>HENRY JAMES - 3700 DORCHESTER ROAD</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Uremia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>16 years</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Renal failure</b>		20. PSYCHOLOGICAL <b>Psychoneurosis</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Nov. 25</b> 19 <b>67</b> to <b>11/25/67</b> and that (I) (we) last saw the deceased alive on <b>Nov. 25</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Jack Brandes</b>		23B. DATE SIGNED <b>11/25/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>JACK BRANDES</b>		23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11-29-67</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>CHARLES R. LAW</b>		ADDRESS <b>802 MADISON AVENUE</b>	

100-50-07

67 11360		BALTIMORE CITY HEALTH DEPARTMENT		67 11360	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD			
SEAB LOVETT		November 20, 1967 2:25 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE			
418 N. Greene St.		Maryland			
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		418 N. Greene St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	Colored		March 2, 1891	75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Porter				Sylvania, Georgia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
		Unknown		unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		577-20-5247		Silena Lovett 418 N. Greene Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
		(A) Pulmonary embolism			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Arteriosclerotic Cardiovascular Disease			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2		YES	YES		
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	(Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER			
Edward F. Wilson, M.D.		ASSOCIATE MEDICAL EXAMINER			
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial	Nov. 25, 1967	Mt. Calvary Cemetery		Brooklyn, Maryland	
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		24D. ADDRESS
NOV 27 1967	Robert E. Taylor		Joseph L. Rose		2222 W. North Ave. Baltimore, Maryland

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THE  
FEDERAL  
BUREAU  
OF  
INVESTIGATION  
OF  
THE  
DEPARTMENT  
OF  
JUSTICE  
WASHINGTON  
D. C. 20535

MEMORANDUM  
FOR THE DIRECTOR  
FROM THE CHIEF OF BUREAU  
SUBJECT: [Illegible]

[Illegible text follows]

Page 1

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-354		67 11361		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11361	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Lillie Stanley		11-24-67 12:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  90 Bolton Hill Convalescent Center				A. STATE Md			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.			
				D. STREET ADDRESS (If rural, give location) 1407 Myrtle Ave.			
5. SEX F	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 2-28-70	9. AGE (In years last birthday) 97	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized Calcemia				CAUSE OF DEATH (A) <u>arteriosclerotic Cardiovascular disease</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 20 years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 8/18/19 6 to 11/24/19 6, that (2) (we) last saw the deceased alive on 11/24/19 6 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Stanley Z. Felsenberg				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/24/67	
23C. PHYSICIAN'S NAME (Type) STANLEY Z. FELSENBURG				23D. ADDRESS M.D. 222 E. Baltimore ST.			
24A. BURIAL CREMATION; REMOVAL (Specify) Burial		24B. DATE 11/26/67		24C. NAME OF CEMETERY • CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Arbutus (Baltimore) Md.	
25A. DATE REC'D BY HEALTH DEPT. NOV 27 1967		25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR Joseph L. Russ		ADDRESS 2222 W. northlan.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-543		67 11362		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11362	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Mildred Aymold</i>			
2. DATE AND HOUR OF DEATH <i>11/26/67 13:15 A.M.</i>				3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 SINAI</i>		(If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BAND 11stown</i> D. STREET ADDRESS (If rural, give location) <i>8906 GREENS LANE</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>6-18-1899</i>	9. AGE (In years last birthday) <i>68</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Physician</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>CARROLL C., Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>Amos M. ARRINGTON</i>				14. MOTHER'S MAIDEN NAME <i>CARRIE O. CARR</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>MARION O. DAVIS - 1001 ST PAUL ST #21202</i>		ADDRESS	
18. I <input checked="" type="checkbox"/> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Wremia</i> DUE TO (B) <i>metastatic Cancer</i> DUE TO (C) <i>undifferentiated Ca of cervix squamous cell</i>				INTERVAL BETWEEN ONSET AND DEATH <i>5-6 days</i> <i>1 year</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Amnesia</i>							
19A. DATE OF OPERATION <i>10/12-10-24</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>bilateral ureteral obst.</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>N/A</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>NA</i>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>NA</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>(the)</del> (this hospital) attended the deceased from <i>10/16</i> 19 <i>67</i> to <i>11/26</i> 19 <i>67</i> , that (I) <del>(was)</del> last saw the deceased alive on <i>11/25</i> 19 <i>67</i> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(the last)</del> view the body after death.							
23A. SIGNATURE <i>Joel Barry Elpers</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>11/26/67</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>11-29-67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 27 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR <i>Ellsworth Amacast</i>		ADDRESS <i>4600 Liberty Heights</i>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<b>M-240</b> BIRTH NO. <b>67 11363</b>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		Registered No. <b>67 11363</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Lowrence Wosley</b>			2. DATE AND HOUR OF DEATH <b>25 Nov 67</b> <b>4:53 p</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Univ Hosp Baltimore</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1924 Penrose Ave.</b>		
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>3/21/15</b>	9. AGE (In years last birthday) <b>52</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Paces, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Abraham Marable</b>			14. MOTHER'S MAIDEN NAME <b>Georgie L. Haynie</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>239-09-5357</b>	17. INFORMANT <b>Georgie L. Gwyn</b>		ADDRESS <b>1515 Lemmon St.</b>
18. <b>053.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <b>Pulmonary Infection</b> DUE TO (B) <b>Bacteremia Septic</b> DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>25 Nov 67</b> to <b>25 Nov 67</b> . that (I) (we) last saw the deceased alive on <b>25 Nov 67</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John W. Eubank</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>25 Nov 67</b>	
23C. PHYSICIAN'S NAME (Type) <b>John W. Eubank</b> M.D.		23D. ADDRESS <b>Univ Md Hosp.</b>			
24A. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11/29/67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MT. AUBURN</b>	
24D. LOCATION <b>Balto., Md.</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; Dye</b>	
				ADDRESS <b>1701 LAURENS</b>	

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H-452

67 11364

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11364

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN HOLMES

2. DATE AND HOUR PRONOUNCED DEAD

November 25, 1967 2:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

48 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

890 Linden Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

9-10-1905

9. AGE (In years  
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

JOHN HOLMES, SR.

14. MOTHER'S MAIDEN NAME

MARY LOUISE WARREN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

213-07-6874

17. INFORMANT

ADDRESS

Mrs. Essie Rozzell 9 N. Amity Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Fatty metamorphosis of liver  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 26, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

11-30-67

23C. NAME of CEMETERY or CREMATORY

Balto. Nat'l Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

NOV 27 1967

Robert E. Fisher, M.D.

MORTON &amp; DYETT F.H. 1701 Laurens St.

VALLEY FORD

NO. 100

4

T-460

67 11365

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11365

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

RICHARD L. TAYLOR

2. DATE AND HOUR PRONOUNCED DEAD

November 25, 1967 11:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

36 Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2132 Mt. Royal Terrace

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

5-8-1949

9. AGE (In years  
last birthday)

18

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Sheraton-Hotel

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOSEPH TAYLOR

14. MOTHER'S MAIDEN NAME

SARAH WILKERSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Sarah Wilkerson 1017 W. Lanvale

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)Duodenal hemorrhage complicating  
cerebrocranial injuries

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

sidewalk

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1200 block N. Mount Street

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
11-10-67 11:45 P.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Injured during altercation

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

November 26 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

11-29-67

23C. NAME of CEMETERY or CREMATORY

ARBUTUS MEMORIAL PK.

23D. LOCATION

ARBUTUS

(City, town, or county)

MARYLAND

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 27 1967

24B. NAME OF REGISTRAR

Robert E. Tarkenton

24C. FUNERAL DIRECTOR

MORTON &amp; DYETT F.H. 1701 Laurens St.

ADDRESS

WALTER H. DORGE

PROSECUTOR GENERAL

MARYLAND



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>P-625</b></p> <p><b>BIRTH NO. 67 11366</b></p>		<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p><b>Registered No. 67 11366</b></p>	
<p><b>M.E. CASE NO.</b></p> <p><b>1. NAME OF DECEASED</b> (Type or Print) <b>May S. Parsons</b></p>			<p><b>2. DATE AND HOUR OF DEATH</b> <b>November 24, 1967 8<sup>55</sup> A.M.</b></p>		
<p><b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1105 E. Fayette Street</b></p>			<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b></p> <p><b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <b>Baltimore</b></p> <p><b>D. STREET ADDRESS</b> (If rural, give location) <b>6657 Collinsdale Rd</b></p>		
<p><b>5. SEX</b> <b>F</b></p>	<p><b>6. RACE</b> <b>W</b></p>	<p><b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b> <b>Widowed</b></p>	<p><b>8. DATE OF BIRTH</b> <b>May 31, 1893</b></p>	<p><b>9. AGE</b> (In years last birthday) <b>74</b></p>	<p><b>If Under 1 Yr. Months Days</b> <b>If Under 24 Hrs. Hours Min.</b></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Clerk</b></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Davison Chemical Co</b></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore Maryland</b></p>	
<p><b>13. FATHER'S NAME</b> <b>James Jeffers</b></p>			<p><b>14. MOTHER'S MAIDEN NAME</b> <b>Christine Widen</b></p>		
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>		<p><b>16. SOCIAL SECURITY NO.</b> <b>215 18 6056A</b></p>	<p><b>17. INFORMANT ADDRESS</b> <b>Mrs. Clayton Emery 6657 Collinsdale</b></p>		
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <b>331X1</b></p>			<p><b>CAUSE OF DEATH</b> (A) <b>CVA</b> <b>DUE TO</b></p>		
<p><b>19. ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Generalized Arteriosclerosis Sev. Yrs.</b></p>			<p><b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 Month</b></p>		
<p><b>20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b> <b>Secondary Anemia</b></p>					
<p><b>19A. DATE OF OPERATION</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		<p><b>20A. AUTOPSY?</b> (Yes or No) <b>No</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner) <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	
<p><b>21D. TIME OF INJURY</b> (APPROX.) 1(Month) 1(Day) 1(Year) 1(Hour)</p>		<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (EXAMINED) attended the deceased from Feb 19 67 to November 23 19 67, that (I) (Saw) lost saw the deceased alive on November 23 19 67 and that in (my) (MY) opinion death occurred on the date and hour and from the causes stated above. (I) (Saw) (did) (view) the body after death.</b></p>					
<p><b>23A. SIGNATURE</b> <b>E. Ellsworth Cook</b> M.D.</p>			<p><b>Attending Phys.</b> <input type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input checked="" type="checkbox"/></p>		<p><b>23B. DATE SIGNED</b> <b>November 24, 1967</b></p>
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>E. Ellsworth Cook</b></p>			<p><b>23D. ADDRESS</b> <b>2431 Maryland Ave</b></p>		
<p><b>24A. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b></p>	<p><b>24B. DATE</b> <b>11/27/67</b></p>	<p><b>24C. NAME of CEMETERY or CREMATORY</b> <b>Parkwood</b></p>	<p><b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore Maryland</b></p>		
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>NOV 27 1967</b></p>		<p><b>25B. NAME OF REGISTRAR</b> <b>Robert E. Farley</b></p>		<p><b>25C. FUNERAL DIRECTOR ADDRESS</b> <b>Leonard J Ruck Inc 5305 Harford Rd</b></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-460 BIRTH NO. 67 11367		BALTIMORE CITY HEALTH DEPARTMENT REGISTERED NO. 67 11367	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
ANNA MILLER		11-25-67 10:21 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		MARYLAND	
5. SEX FEMALE		6. RACE WHITE	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH Feb. 1, 1893.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Peter England		14. MOTHER'S MAIDEN NAME Sarah Wheeler	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-22-2177	
17. INFORMANT Mr. Charles H. Miller, Boardman, Ohio		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) 260X I Probable Acute Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 14 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None		(B) Arteriosclerotic Cardiovascular Disease 10-15 years	
(C) Probable Diabetes Mellitus Many years		19A. DATE OF OPERATION 2	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 11/22 19 67 to 11/25 19 67, that (2) (we) last saw the deceased alive on 11/25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		23A. SIGNATURE John R. Stone M.D.	
23B. DATE SIGNED 11/25/67		23C. PHYSICIAN'S NAME (Type) JOHN R. STONE	
23D. ADDRESS JOHNS HOPKINS HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 11/28/67		24C. NAME of CEMETERY or CREMATORY Landon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE RECD BY HEALTH DEPT. NOV 27 1967	
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	

10. 1. 1941

10. 1. 1941

10. 1. 1941

10. 1. 1941

10. 1. 1941

10. 1. 1941

10. 1. 1941

10. 1. 1941

10. 1. 1941

10. 1. 1941

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10. 1. 1941

10. 1. 1941

10. 1. 1941

10. 1. 1941

10. 1. 1941

10. 1. 1941

10. 1. 1941

10. 1. 1941

10. 1. 1941

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-540		67 11368		BALTIMORE CITY DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 11368	
BIRTH NO. <b>C-540</b>				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>MIRIAM R. CONNOLLY</b>				2. DATE AND HOUR OF DEATH <b>Nov. 24, 1967</b> <span style="float: right;"><b>2:30 P.M.</b></span>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>1126 E. 36th St.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1126 E. 36th St.</b>			
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>July 3, 1878</b>	9. AGE (In years last birthday) <b>89</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Richard E. Brown</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Slaysman</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>216-46-1837</b>		17. INFORMANT ADDRESS <b>James H. Connolly: 55 Franklin Ave, Rye, N.Y.</b>		
18. <b>491 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Broncho Pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH <b>Broncho Pneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>acute</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 1, 1947</b> to <b>Nov 24, 1967</b> and that (I) (we) last saw the deceased alive on <b>Nov 24, 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>C. J. Mendelis</b> M.D.				23B. DATE SIGNED <b>11-25-67</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dr. Christopher J. Mendelis</b> M.D.				23D. ADDRESS <b>2308 Edmondson Ave, Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>11-28-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc: Balto., Md....14</b>		ADDRESS	

Revised

Nov 24

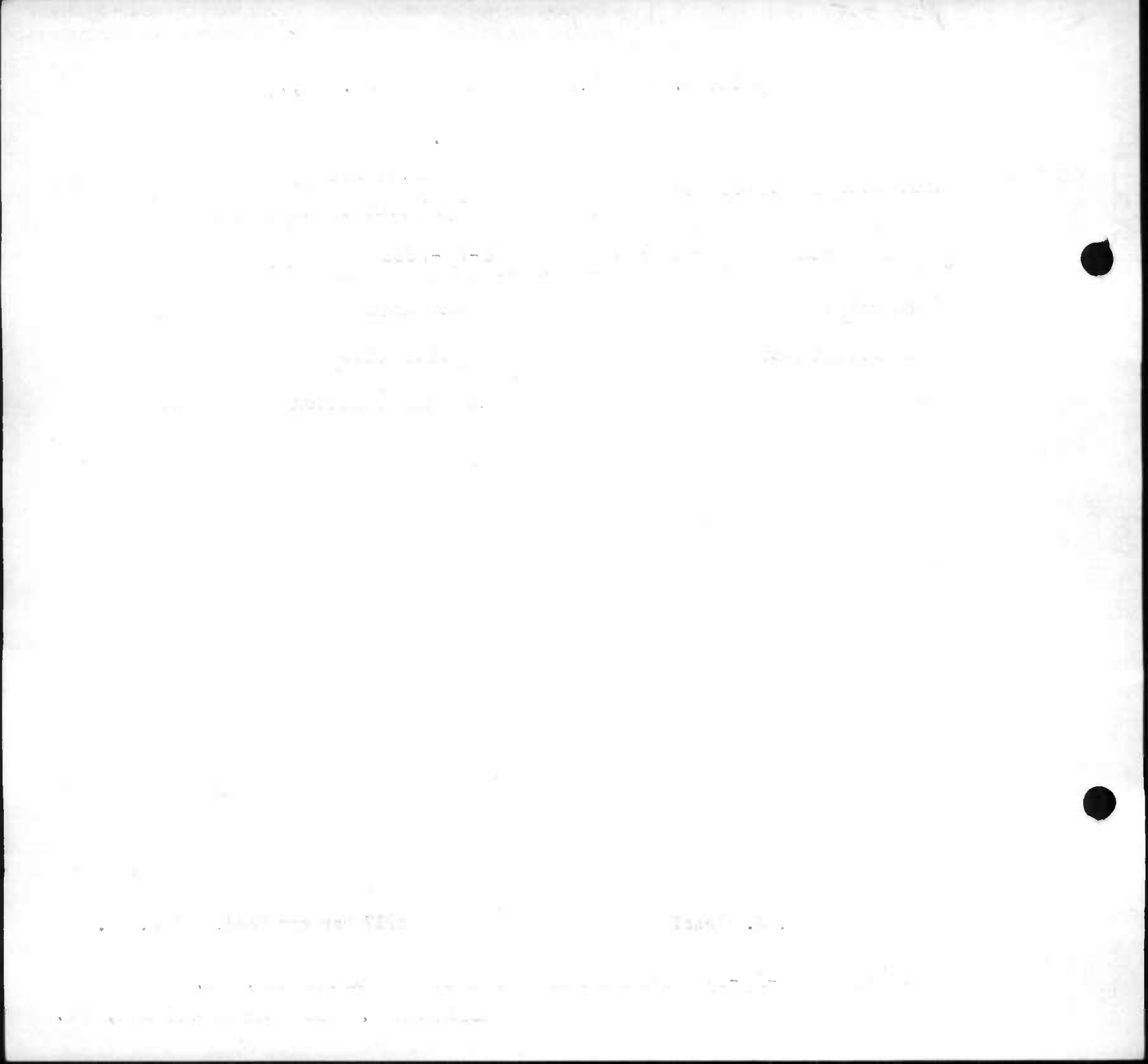
Efficient

11-25

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
P-625		67 11369				CERTIFICATE OF DEATH		Registered No. 67 11369	
BIRTH NO.		M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		Edith H. Perkins				Nov. 26, 1967		4:25 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
Pine Ridge Nursing Home					Md. Balt. Co.				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					Baltimore 34				
					D. STREET ADDRESS (If rural, give location)				
					2912 Kings Ridge Road				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
female	white	widowed	8-13-1888	79	Housewife	Maryland	USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Robert Snyder					Edith Kirby				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
no							Mrs Mabel Hanson same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				
arteriosclerotic heart disease					INTERVAL BETWEEN ONSET AND DEATH				
5 years									
19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0				No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from June 17 1967 to November 26 1967, that (I) (we) last saw the deceased alive on November 26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED	
E. J. Alessi								11/27/67	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
					6217 Harford Road, Balto. Md.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		11-29-67		Loudon Park Cemetery		Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			ADDRESS		
NOV 27 1967		Robert E. F. F. F.		Leonard J. Ruck Inc			Baltimore, Md.		





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-520		67 11370		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11370	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>RANDOLPH JACKSON THOMAS</b>				2. DATE AND HOUR OF DEATH <b>Nov. 27, 1967</b> <b>13.4</b> <b>A. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1505 Pentridge Road...14</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>1505 Pentridge Road...14</b>			
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>Jan. 2, 1899</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired owner, truck route for A &amp; P Co.</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Grasonville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Jackson W. Thomas</b>			14. MOTHER'S MAIDEN NAME <b>Essie Trott</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>218-32-4905</b>		17. INFORMANT ADDRESS <b>Mrs. Randolph J. Thomas: 1505 Pentridge Rd, 14</b>		
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary heart disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Atherosclerotic CVD</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <b>Since 1959</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Bronchial asthma + emphysema</b>				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>JAN 9, 1962</b> to <b>Nov 9, 1967</b> , that (I) <del>we</del> last saw the deceased alive on <b>Nov 9, 1967</b> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Sidney Scherlis</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11-27-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Sidney Scherlis</b>				23D. ADDRESS <b>11 E. Chase St., Balto., Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/30/67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc....Balto., Md....14</b>		ADDRESS	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>S-263</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 11371</b>	
M.E. CASE NO.		67 11371		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		LAURA M. SWIGERT		2. DATE AND HOUR OF DEATH <b>November 24, 1967. 11:45 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>90 Harford Gardens Nursing Home</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 21214 27-44</b> D. STREET ADDRESS (If rural, give location) <b>3202 Gibbons Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>May 12, 1886.</b>	9. AGE (In years lost birthday) <b>81</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Tutor</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Penna</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Henry W. Swigert</b>		14. MOTHER'S MAIDEN NAME <b>Lydia A. Mundorff</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218541131T</b>		17. INFORMANT ADDRESS <b>Mrs. Lydia C. Kelly (Same)</b>	
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Cerebral Vascular Accident</b> DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>			
MEDICAL CERTIFICATION: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>May 67</b> to <b>Nov. 67</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>22 Nov. 67</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <del>(did)</del> (did not) view the body after death.					
23A. SIGNATURE <b>Wm. H. Kammer, Jr.</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>27 Nov. 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>William H. Kammer, Jr.</b>		23D. ADDRESS <b>6011 York Rd. Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/27/67.</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>	

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**FUNERAL DIRECTOR: IMPORTANT**

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Q-500		67 11372		BALTIMORE CITY HEALTH DEPARTMENT		67 11372	
BIRTH NO.		CERTIFICATE OF DEATH				Registered No.	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <b>Elizabeth C Quinn</b>				2. DATE AND HOUR OF DEATH <b>11-23-67</b> <b>10 P</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>2904 Sylvan Avenue...14</b>				A. STATE <b>Maryland</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
D. STREET ADDRESS (If rural, give location) <b>2904 Sylvan Ave....14</b>				27-07			
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>		8. DATE OF BIRTH <b>10-15-94</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John J. Kilchenstein</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Shilling</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>8435-44K-220-46-</b>		17. INFORMANT ADDRESS <b>Robert J. Quinn: 2904 Sylvan Ave, Balto. 14</b>			
18. <b>334 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Hemiplegia</b> DUE TO (B) <b>Cerebral arteriosclerosis</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1947</b> to <b>November 23, 1967</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>February</b> 19 <b>67</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>Donald Jandorf</b> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11-23-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. R. Donald Jandorf</b>				23D. ADDRESS <b>6077 Harford Rd, Balto, Md....14</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>11/27/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc: Balto., Md....14</b>		ADDRESS	

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J-520

67 11373

BALTIMORE CITY HEALTH DEPARTMENT

67 11373

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

## 1. NAME OF DECEASED

(Type or Print)

HARRY

M.

JONES

## 2. DATE AND HOUR PRONOUNCED DEAD

November 24, 1967

11:25 A.M.

## 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

2710 Beechland Avenue

## 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

## C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

## D. STREET ADDRESS (If rural, give location)

2710 Beechland Avenue

## 5. SEX

Male

## 6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

never married

## 8. DATE OF BIRTH

Oct. 28, 1920

9. AGE (In years  
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Operator, paper route

## 10B. KIND OF BUSINESS OR INDUSTRY

The Sun, Balto.

## 11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

## 13. FATHER'S NAME

Manley M. Jones

## 14. MOTHER'S MAIDEN NAME

Sarah N. Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

yes

WW II

16. SOCIAL  
SECURITY NO.

214-14-1681

## 17. INFORMANT

## ADDRESS

Mrs. Sarah Jones (mother) 2710 Beechland Ave.

## 18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

## 19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

## 20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

## 21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

## 21F. HOW DID INJURY OCCUR?

## 22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/24/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

burial

## 23B. DATE

11/28/67.

## 23C. NAME OF CEMETERY or CREMATORY

Baltimore National

## 23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

## 24A. DATE REC'D BY HEALTH DEPT.

NOV 27 1967

## 24B. NAME OF REGISTRAR

Robert E. Farber

## 24C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc: Baltimore, Md....14

## ADDRESS

Oct. 28, 1930

never married

THE

Baltimore, Md.

The Sun, Balto.

Director, Dept. of

John W. Johnson

James H. Jones

The Sun (Baltimore) 210 West

210-11-1081

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Baltimore, Md.

Baltimore Eastern

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Letter

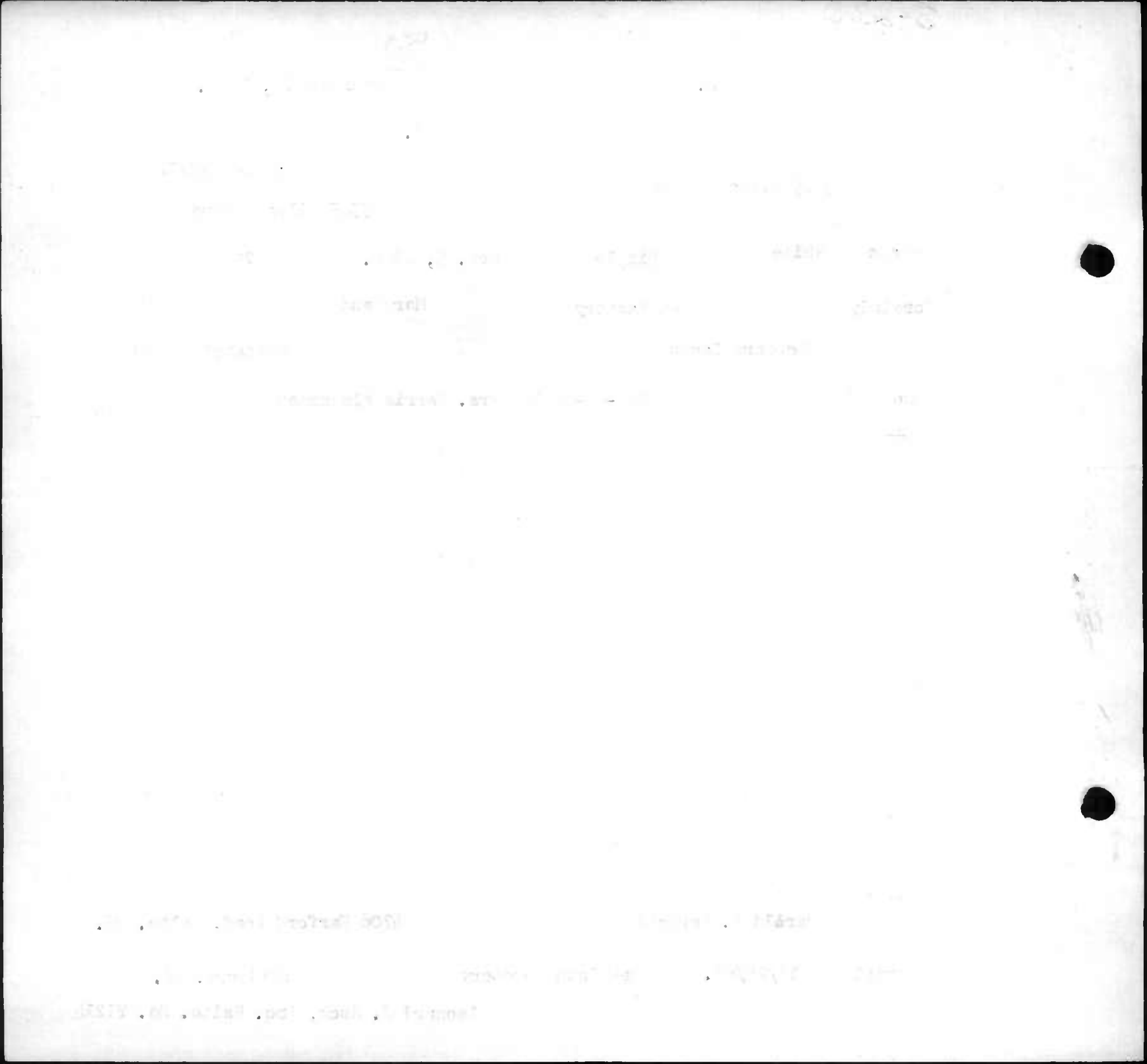
Leonard J. Fox, Inc. Baltimore, Md.



**FUNERAL DIRECTOR: IMPORTANT**

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S-200 67 11374		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 67 11374	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				<b>ELSIE J. SACHS</b>	
2. DATE AND HOUR OF DEATH		November 25, 1967. 5:55 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  00 3309 Ailsa Avenue		A. STATE <b>Md.</b> B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 21214</b>			
		D. STREET ADDRESS (If rural, give location) <b>3309 Ailsa Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>Nov. 9, 1888.</b>	9. AGE (in years last birthday) <b>79</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Forelady</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Hat Factory</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Theodore Sachs</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Young</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-05-8945A</b>		17. INFORMANT <b>Mrs. Carrie Alexander</b>	
				ADDRESS <b>(Same)</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>422.11</b>		CAUSE OF DEATH (A) DUE TO <b>Acute pulmonary edema</b> (B) DUE TO <b>Chronic Myocarditis</b> (C) DUE TO <b>Arteriosclerosis C.V. Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Severe Parkinson's disease</b>		<b>25 yrs</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 19 44</b> to <b>November 25 19 67</b> , that (I) (we) last saw the deceased alive on <b>Nov. 25 19 67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>H.V. Harbold</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Nov. 27, 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>Harold V. Harbold</b>		23D. ADDRESS <b>4706 Harford Road, Balto. Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/29/67.</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>	



**FUNERAL DIRECTOR: IMPORTANT**

DR. LINTHICUM ME

VS 150-REV. 1/1/65

THE OFFICE OF THE ATTORNEY GENERAL  
WASHINGTON, D. C.  
JULY 1, 1914

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DEPT. OF JUSTICE

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JULY 1, 1914

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JULY 1, 1914

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JULY 1, 1914

JULY 1, 1914

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-320		67 11376		BALTIMORE CITY HEALTH DEPARTMENT		67 11376	
BIRTH NO.		M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <u>RUSSELL G. MATTHEWS</u>				2. DATE AND HOUR OF DEATH <u>11/24/67</u> <u>305 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>MARYLAND GENERAL HOSPITAL</u> <u>827 LINDEN AVENUE</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>27-38</u> D. STREET ADDRESS (If rural, give location) <u>1726 E. BELVEDERE</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>5-11-1895</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CASHIER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>GOV'T. (STATE)</u>		11. BIRTHPLACE (State or foreign country) <u>CAMBRIDGE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN S. MATTHEWS</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET E. DOOSON</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>212-26-9948</u>		17. INFORMANT <u>HELEN B. MATTHEWS</u>		ADDRESS <u>ABOVE</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>420.11</u> <u>Myocardial Infarction</u>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u> <u>10 yrs</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <del>this hospital</del> attended the deceased from <u>January</u> 19 <u>59</u> to <u>November 24</u> 19 <u>67</u> , that (I) <del>was</del> last saw the deceased alive on <u>November 10</u> 19 <u>67</u> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did) <del>not</del> view the body after death.							
23A. SIGNATURE <u>A. Allan Spier</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>11/24/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. A. llan Spier</u>				23D. ADDRESS M.D. <u>1501 Pentridge Rd., Balto., Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-27-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenlawn</u>		24D. LOCATION (City, town, or county) (State) <u>Cambridge</u> <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 27 1967</u>		25B. NAME OF REGISTRAR <u>R. B. E. Fickens</u>		25C. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins &amp; Sons Co. 4905 York Rd.</u>			

© R. 1911

Mrs. White  
123 Cedar St.  
1732 E. 1st Ave.

Mrs. White  
2-11-1892

White (Mrs.)  
1732 E. 1st Ave.

White (Mrs.)  
1732 E. 1st Ave.

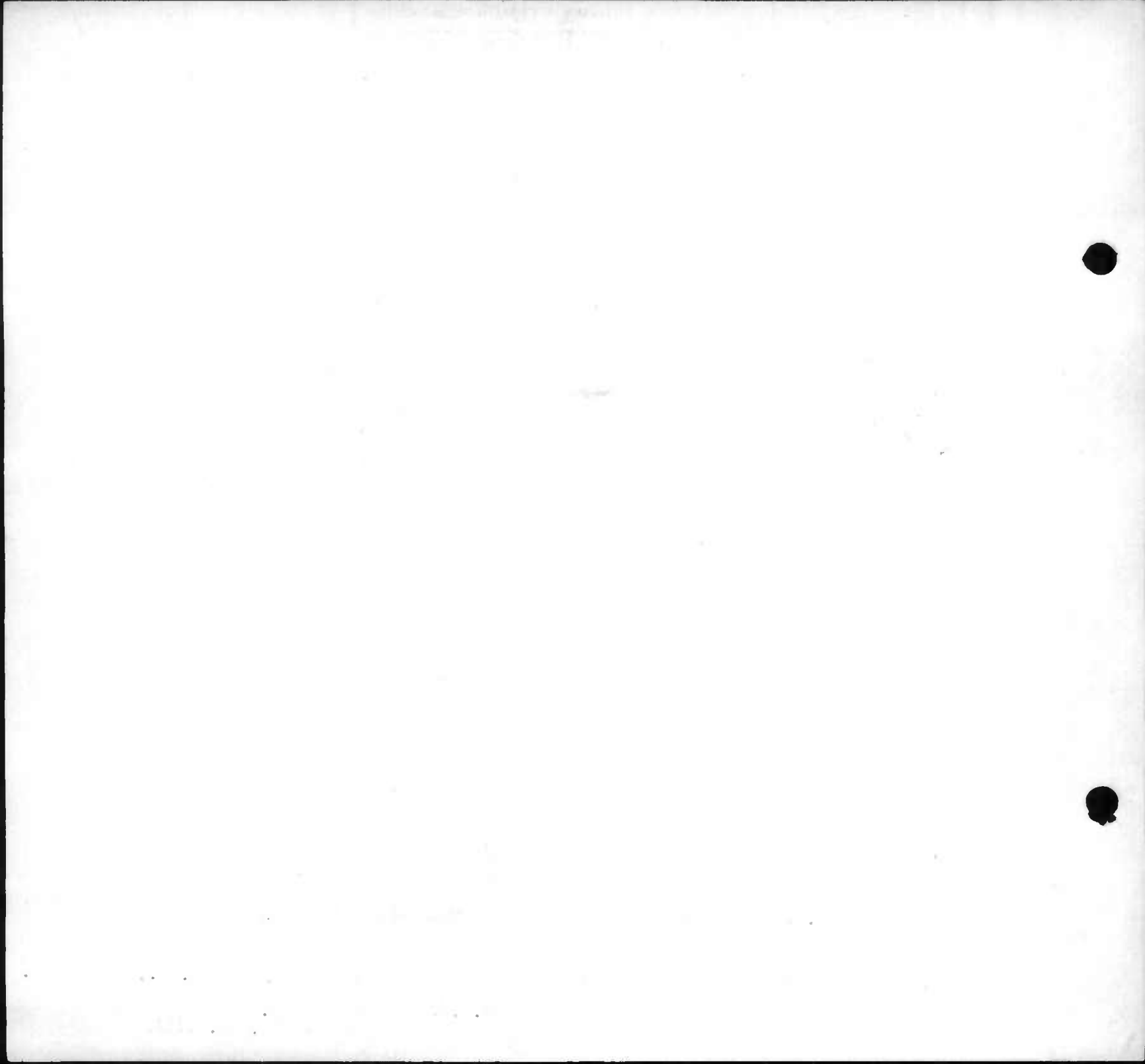
White (Mrs.)  
1732 E. 1st Ave.

No

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-260		67 11377		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11377	
BIRTH NO.							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <b>Leila V. Maser</b>				2. DATE AND HOUR OF DEATH <b>11/25/67 12<sup>45</sup> A</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Maryland General Hospital</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>MD</b>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 21206 26-01</b>			
				D. STREET ADDRESS (If rural, give location) <b>4220 Powell Ave</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>6/22/04</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Queen Anne's Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Millard Summers</b>				14. MOTHER'S MAIDEN NAME <b>Laura Burrows</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT ADDRESS <b>Hospital Chart</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) <b>Carcinoma of Breast</b> DUE TO (B) <b>Widespread Metastasis</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11/24 19 67</b> to <b>11/25 19 67</b> and that (I) (we) last saw the deceased alive on <b>11/24 19 67</b> and that (I) (my) (ap) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>D. Lindenstruth</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/25/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>D. Lindenstruth</b>		23D. ADDRESS <b>Maryland General Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/28/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Parkwood</b>		24D. LOCATION (City, town, or county) (State) <b>Parkville, Balto. Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Road Baltimore, Md. 21212</b>			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
B-200		67 11378		67 11378	
BIRTH NO.				M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <b>MARIE K. BAESCH</b>				2. DATE AND HOUR OF DEATH <b>11-26-67 6:30 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
<div style="font-size: 2em; font-weight: bold; position: absolute; top: 0; left: 0;">CERTIFICATE AMENDED</div> <div style="position: absolute; top: 10px; right: 10px;">12/4/67</div>				A. STATE <b>MARYLAND</b>	
				B. COUNTY <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>37 MERCY HOSPITAL</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>9-02</b>	
D. STREET ADDRESS (If rural, give location) <b>3711 LOCH RAVEN BLVD.</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>12-17-09</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Charles Dudley Fitzpatrick</b>			14. MOTHER'S MAIDEN NAME <b>Fralinger</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>216-46-2498</b>		17. INFORMANT <b>HERMAN R. BAESCH</b>
			ADDRESS <b>ABOVE</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
			(A) DUE TO <b>Cardiac standstill</b> (B) DUE TO <b>ca fatum</b> (C)		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? If in Baltimore City, give exact location	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from <b>10/11</b> 19 <b>67</b> to <b>11/26</b> 19 <b>67</b> , that (he) (we) last saw the deceased alive on <b>11/26</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Parriz Khajeb Amid</b>				23B. DATE SIGNED <b>11/26/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>PARRIZ KHAJEB AMID</b>				23D. ADDRESS <b>Mercy Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-29-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 27 1967</b>		25B. NAME OF REGISTRAR <b>W. E. Fisher</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>	
				ADDRESS <b>4905 York Rd.</b>	

12/4/61 - Carcasses from Funeral Director.  
H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 11379	
67 11379 CERTIFICATE OF DEATH				Registered No. 67 11379	
BIRTH NO. M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WALLER, MR. DAVID		Nov. 24, 1967 7:00 A.M. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
CHURCH HOME AND HOSPITAL 100 N. BROADWAY BALTIMORE, MARYLAND 21201		ARMISTEAD HOTEL, C. CITY OR TOWN (If outside city limits, write RURAL and give township) 17-19 HOLLIDAY STREET D. STREET ADDRESS (If rural, give location) BALTIMORE, MARYLAND 21202			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
MALE	WHITE	SINGLE	1/16/1912	55	U.S.A
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
SALESMAN		RETAIL		BALTIMORE MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
ISAAC WALLER			ANNIE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		220 22 1944		MR. HARRY WALLER, P.O., BOX 866 #21203	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) SEPTICEMIA (B) CEREBRAL HEMORRHAGE (C) LIVER CIRRHOSIS D) AZOTEMIA, ANEMIA			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH days			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-17 1967 to 11-24 1967. that (I) (we) last saw the deceased alive on 11-24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ephraim Barzaga M.D.				23B. DATE SIGNED 11-24-67	
23C. PHYSICIAN'S NAME (Type) EPHRAIM BARZAGA M.D.				23D. ADDRESS CHURCH HOME & HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		11-26-67		BETH TFILOH	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 28 1967		R. L. E. Taylor, MD		SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD	

OFFICE MEMO  
GENERAL MEMORANDUM  
JAMES C. HARRIS  
2000

100

100-11-10

100-11-10

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

RICHARD CHERNEY

2. DATE AND HOUR PRONOUNCED DEAD

November 22, 1967 9:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

7017 Wallis Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

12-15-1951

9. AGE (In years  
last birthday)

15

If Under 1 Yr. If Under 24 Mos.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

STUDENT

10B. KIND OF BUSINESS OR INDUSTRY

SCHOOL

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

IRVING CHERNEY

14. MOTHER'S MAIDEN NAME

ELAINE JOFFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

220-48-5670

17. INFORMANT

ADDRESS

MR. IRVING CHERNEY, 7017 WALLIS AVENUE

18.

E 823.4

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Cerebrocranial injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

11-21-67

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

Head Injury

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Stevenson Road 146' north  
of Haleyon Road21D. TIME  
OF INJURY  
(APPROX.)

11-3-67

11:01 P.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Passenger in auto that struck a tree

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

November 23, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

11-24-67

23C. NAME of CEMETERY or CREMATORY

BALTIMORE HEBREW

23D. LOCATION

(City, town, or county)

BALTIMORE, MARYLAND

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 28 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

6010 REISTERSTOWN ROAD

ADDRESS

NO

IRVING CHERNEY

STUDENT

SCHOOL

GRADE

12-12-1981

BALTIMORE, MARYLAND

BLAIR JEFF

110-42-2570 MR. IRVING CHERNEY, 7017 LAMAR AVENUE

Investigative Division

11-11-81

11-11-81

NO

11-11-81

11-11-81

11-11-81

11-11-81

BALTIMORE, MARYLAND

BALTIMORE, MARYLAND

11-11-81

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-142		67 11381		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11381	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) X APPLESTEIN, MYRTLE				X 11/22/67 8:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hersina Hosp. of Baltimore.				A. STATE X MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2941 MARNAT ROAD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 9-16-1913	9. AGE (In years last birthday) 54	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE		10B. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LOUIS APPLESTEIN				14. MOTHER'S MAIDEN NAME JENNIE KIRSCH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT PARK TOWERS, APT. 610 MRS. MYER J. COHEN, 7121 PARK HIGHTS, AVENUE #15			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.01 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) POSSIBLE pulmonary embolus (B) atrial fibrillation (C) A.S.H.P. extreme obesity		INTERVAL BETWEEN ONSET AND DEATH instantaneous 1 Month			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/24 1967 to 11/22 1967, that (I) (we) last saw the deceased alive on 11/24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Bernard Burgin				23B. DATE SIGNED 11/22/67			
23C. PHYSICIAN'S NAME (Type) BERNARD BURGIN				23D. ADDRESS 6721 Reisterstown Rd. Balto. Md. 21215			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-23-67		24C. NAME OF CEMETERY or CREMATORY CHIZUK AMUNO		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. NOV 28 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD			

THE UNITED STATES

1913-1914

DEPARTMENT OF AGRICULTURE

WASHINGTON

FOR THE YEAR 1913-1914

BARNARD BAKER

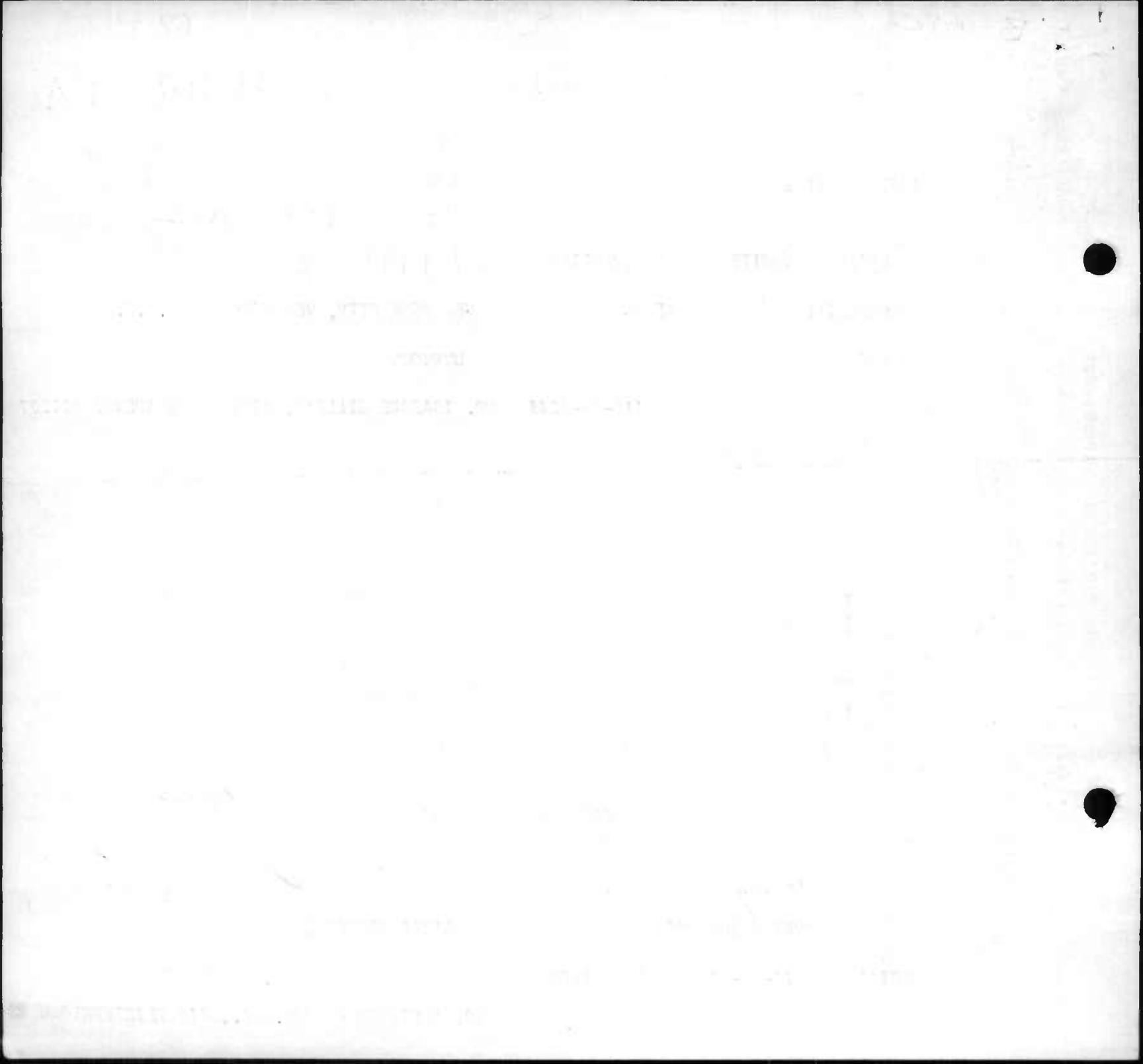
UNITED STATES DEPARTMENT OF AGRICULTURE



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>67 11382</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 11382</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>ESTHER BILLIAN</b>		2. DATE AND HOUR OF DEATH <b>NOV 23 1967 9<sup>10</sup> A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>28-02</b> D. STREET ADDRESS (If rural, give location) <b>4308 MAINE AVE</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>5/14/94</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>NEW YORK CITY, NEW YORK</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>113-09-6243</b>		17. INFORMANT ADDRESS <b>MR. ISADORE BILLIAN, 4308 MAINE AVENUE #21207</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>420.1 I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <b>ANTecedent CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <b>Coronary A.S.H.D.</b> DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>9</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/31/67</b> 19 to <b>11/23</b> 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>11/23</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Myung Sun Yoon</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>NOV. 23, 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>MYRONG SUN YOON</b>		23D. ADDRESS M.D. <b>SINAI HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>11-24-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>BETH TFILOH</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 28 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD</b>	



S-5001

67 11383

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

67 11383

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

SWANN, Harry Raymond

2. DATE AND HOUR OF DEATH

11/24/67

7:10

P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Veterans Administration Hospital  
3900 Loch Raven Boulevard  
Baltimore, Maryland 212184. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2862 Kentucky Avenue

5. SEX

Male

6. RACE

Caucasian

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

11/1/92

9. AGE (In years  
last birthday)

75

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Printer-cutter

10B. KIND OF BUSINESS OR INDUSTRY

UNK

11. BIRTHPLACE (State or foreign country)

Calvert County, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Swann

14. MOTHER'S MAIDEN NAME

unknown

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

7/21/17 to 6/11/19

16. SOCIAL  
SECURITY NO.

215-03-94-03

17. INFORMANT

Joseph Swann, son, 3936 Kenyon Ave.  
Hospital Records 21213

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Broncho Pneumonia, left upper lobe

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

2 weeks

(B) Bronchogenic Carcinoma right

DUE TO upper lobe, widespread metastasis

Months

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Arteriosclerosis, generalized

Years

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from September 9, 1967 to November 24, 1967, that (X) (we) last saw the deceased alive on November 24, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Alfonso A. Lopez Jr.

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

11/24/67

23C. PHYSICIAN'S  
NAME (Type)

ALFONSO A. LOPEZ JR.

M.D.

23D. ADDRESS

3900 Loch Raven Blvd, Baltimore, Md 21218

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

11/28/67

24C. NAME OF CEMETERY or CREMATORY

Balto. Nat. Cem.

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

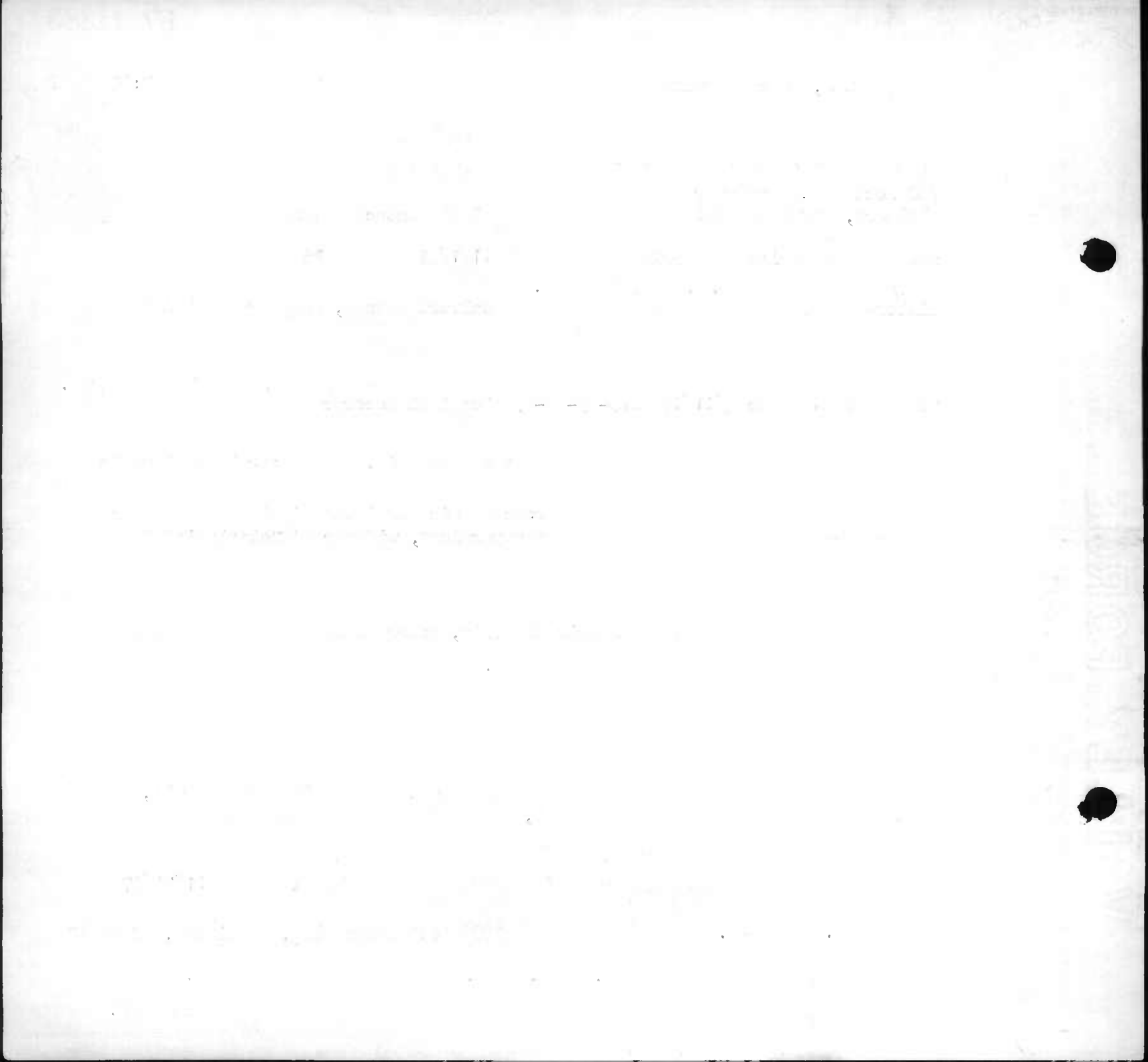
25C. FUNERAL DIRECTOR

ADDRESS

Schimunek Funeral Home, Inc.  
3331 Brehms Lane

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



T-460

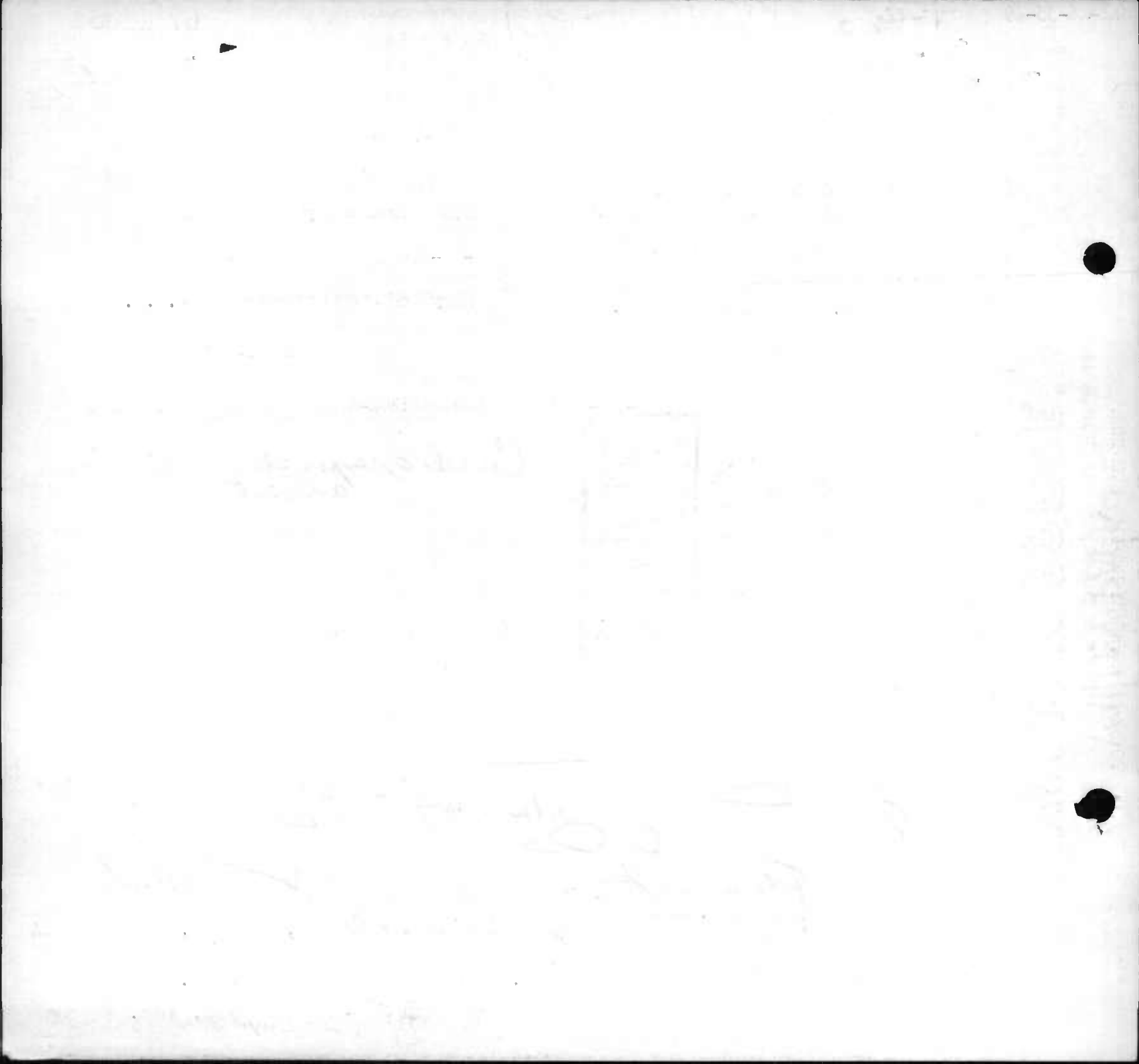
BALTIMORE CITY HEALTH DEPARTMENT  
67 11384 CERTIFICATE OF DEATH

Registered No. 67 11384

BIRTH NO. M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		TAYLOR Joseph L.		11/24/67 10 <sup>25</sup> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				Maryland	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				Baltimore	
				D. STREET ADDRESS (If rural, give location)	
				4595 Freedomway 21213	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Male	White	Married	9-16-1901	66	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Food Mgr. Lord Balto. Hotel			Maryland, Baltimore		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
unknown			Nellie unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		216-03-3689A		Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, leading to the above cause (A) slowing the UNDERLYING CONDITION last.			(A) DUE TO		< 1 hour
			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			unknown		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/24 1967 to 11/24 1967, that (I) (we) lost saw the deceased alive on 11/24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Franklin G. Strauss M.D.				11/24/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
FRANKLIN G. STRAUSS		4940 Eastern Avenue, Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/28/67		Moreland Mem. Park	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 28 1967		Robert E. Schimunek		Schimunek Funeral Home, Inc. 3331 Brehms Lane	

TO BE APPROVED BY MEDICAL EXAMINER  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>K-600</b>      <b>67 11385</b>      <b>CERTIFICATE OF DEATH</b>      Registered No. <b>67 11385</b></p>	
<p><b>BIRTH NO.</b>      <b>M.E. CASE NO.</b></p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print)      <b>KROH, CORA</b></p>	
<p><b>2. DATE AND HOUR OF DEATH</b> <b>NOVEMBER 25, 1967</b>      <b>7:25AM</b>      M.</p>	
<p><b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b></p>	
<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE      B. COUNTY <b>MARYLAND</b>      <b>21228</b>      <i>Balt Co</i></p>	
<p><b>5. SEX</b>      <b>6. RACE</b>      <b>7. MARRIED, NEVER MARRIED</b> <b>FEMALE</b>      <b>WHITE</b>      <b>WIDOWED</b>      <b>DIVORCED (specify)</b></p>	
<p><b>8. DATE OF BIRTH</b>      <b>9. AGE</b> (In years last birthday)      <b>10. A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)      <b>10B. KIND OF BUSINESS OR INDUSTRY</b>      <b>11. BIRTHPLACE</b> (State or foreign country)      <b>12. CITIZEN OF WHAT COUNTRY?</b></p>	
<p><b>13. FATHER'S NAME</b>      <b>14. MOTHER'S MAIDEN NAME</b> <b>AUGUSTUS BRUNSMAN</b>      <b>VIRGINIA HICKS</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)      <b>16. SOCIAL SECURITY NO.</b>      <b>17. ST. AGNES HOSPITAL RECORDS ADDRESS</b></p>	
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>      <b>CAUSE OF DEATH</b>      <b>INTERVAL BETWEEN ONSET AND DEATH</b></p>	
<p><b>19. DATE OF OPERATION</b>      <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>      <b>20A. AUTOPSY?</b> (Yes or No)      <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)      <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)      <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)      <b>21E. INJURY OCCURRED</b>      <b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that</b> (X) (this hospital) attended the deceased from <b>NOVEMBER 18</b> 19 <b>67</b> to <b>NOVEMBER 25</b> 19 <b>67</b>, that (X) (we) last saw the deceased alive on <b>NOVEMBER 25</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (X) (we) (did) (XXX) (not) view the body after death.</p>	
<p><b>23A. SIGNATURE</b>      <b>23B. DATE SIGNED</b></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type)      <b>23D. ADDRESS</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b>      <b>24B. DATE</b>      <b>24C. NAME OF CEMETERY or CREMATORY</b>      <b>24D. LOCATION</b> (City, town, or county)      (State)</p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b>      <b>25B. NAME OF REGISTRAR</b>      <b>25C. FUNERAL DIRECTOR</b>      <b>ADDRESS</b></p>	

NOVEMBER 22, 1961

MARYLAND 21220

112 FOREST DRIVE

10-23-61

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MARYLAND

VIRGINIA HICKS

ST. AGNES HOSPITAL

215 43 3408 CATON & WICKENS AVE., S.W.

21220

HICKMAN

FEMALE WHITE

WICKENS AVE.

NOV 22 1961

21220

CATON & WICKENS AVE.

DR. GARDNER

21220



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>Registered No. <b>67 11386</b></p>	
<p><b>BIRTH NO.</b> <b>7-460</b> <b>67 11386</b></p>			
<p><b>M.E. CASE NO.</b></p> <p><b>1. NAME OF DECEASED</b> (Type or Print) <b>TAYLOR, EMILY I</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <b>11/23/67 7:15 P.M.</b></p>	
<p><b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>40 ST AGNES HOSPITAL</b></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY _____</p> <p><b>5. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <b>BALTIMORE 21229</b></p> <p><b>6. STREET ADDRESS</b> (If rural, give location) <b>4227 FREDERICK AVENUE</b></p>	
<p><b>5. SEX</b> <b>FEMALE</b></p>	<p><b>6. RACE</b> <b>WHITE</b></p>	<p><b>7. MARRIED, NEVER MARRIED</b> <b>WIDOW</b></p>	<p><b>8. DATE OF BIRTH</b> <b>06/13/04</b></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>OWN HOME</b></p>	<p><b>9. AGE</b> (In years last birthday) <b>63</b></p>
<p><b>11. BIRTHPLACE</b> (State or foreign country) <b>WEST VIRGINIA</b></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b></p>	
<p><b>13. FATHER'S NAME</b> <b>JAMES MASON</b></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <b>FRANCES ESTEP</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b></p>		<p><b>16. SOCIAL SECURITY NO.</b> <b>277-16-0681-d</b></p>	
<p><b>17. INFORMANT</b> <b>ST AGNES RECORDS-WILKENS &amp; CATON AVES.</b></p>			
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>43311121X</b></p>		<p><b>CAUSE OF DEATH</b> (A) <b>Congestive heart failure</b> <b>DUE TO</b></p>	
<p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Actual Fibrillations</b></p>		<p><b>INTERVAL BETWEEN ONSET AND DEATH</b> (B) <b>D.S.E.V.D.</b> <b>DUE TO</b></p>	
<p><b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Co of. Currr. Stage 0-</b></p>			
<p><b>19A. DATE OF OPERATION</b> <b>0</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	
<p><b>20A. AUTOPSY?</b> (Yes or No) <b>NO</b></p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner) <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>			
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p><b>21F. HOW DID INJURY OCCUR?</b></p>			
<p><b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>NOVEMBER 15</b> <b>19 67</b> <b>to</b> <b>NOVEMBER 23</b> <b>19 67</b>, <b>that (I) (we) last saw the deceased alive on</b> <b>NOVEMBER 23</b> <b>19 67</b> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <i>Alejandro Mejia</i></p>		<p><b>23B. DATE SIGNED</b> <b>11/23/67</b></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>ALEJANDRO MEJIA</b></p>		<p><b>23D. ADDRESS</b> <b>ST AGNES HOSPITAL-WILKENS &amp; CATON AVES.</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>TRANSPORTATION</b></p>		<p><b>24B. DATE</b> <b>11/25/67</b></p>	
<p><b>24C. NAME OF CEMETERY or CREMATORY</b> <b>HUSE MEMORIAL PARK</b></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State) <b>FAYETTEVILLE FAYETTE CO. W. VA.</b></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>NOV 28 1967</b></p>		<p><b>25B. NAME OF REGISTRAR</b> <i>Robert E. Fairburn</i></p>	
<p><b>25C. FUNERAL DIRECTOR</b> <i>Easton Funeral Home</i></p>		<p><b>ADDRESS</b> <i>Catonville, Md</i></p>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>67 11387 CERTIFICATE OF DEATH</b></p>		<p>Registered No. <b>67 11387</b></p>	
<p><b>BIRTH NO.</b> <b>L-532</b></p>		<p><b>M.E. CASE NO.</b></p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print) <b>Linthicum Mr. Charles M.</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <b>Nov. 25, 1967 12<sup>05</sup> A.M.</b></p>	
<p><b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b></p> <p><b>CERTIFICATE AMENDED</b> <b>91 Keswick 12/8/67</b></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>13-07</b> D. STREET ADDRESS (If rural, give location) <b>700 W. 40<sup>th</sup> Street</b></p>	
<p><b>5. SEX</b> <b>MALE</b></p>	<p><b>6. RACE</b> <b>WHITE</b></p>	<p><b>7. MARRIED, NEVER MARRIED</b> <b>WIDOWED, DIVORCED (specify)</b></p>	<p><b>8. DATE OF BIRTH</b> <b>7-27-1883</b> <b>9. AGE</b> (In years last birthday) <b>84 85</b></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Salesman</b></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>OIL BUSINESS</b></p>	<p><b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Md.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b></p>
<p><b>13. FATHER'S NAME</b> <b>Charles W. Linthicum</b></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <b>UNKNOWN</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>		<p><b>16. SOCIAL SECURITY NO.</b> <b>216-05-5654</b></p>	<p><b>17. INFORMANT</b> <b>Mrs. Rowland M. Ness 205 St. Dunstons Rd. Helen G. Leary, 11-11- Keswick</b></p>
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>420.01</b></p>		<p><b>CAUSE OF DEATH</b> (A) <b>Heart failure due to</b> (B) <b>Coronary Heart Disease 1 year</b> (C) <b>Generalized atherosclerosis 5 yrs</b></p>	
<p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p><b>INTERVAL BETWEEN ONSET AND DEATH</b></p>	
<p><b>II</b></p>			
<p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b></p>			
<p><b>19A. DATE OF OPERATION</b> <b>0</b></p>	<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	<p><b>20A. AUTOPSY?</b> (Yes or No)</p>	<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>	<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)</p>	<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from Jan. 29 1962 to Nov. 25 1967, that (I) (we) last saw the deceased alive on 11-24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <b>E. Hunter Wilson, M.D.</b></p>		<p><b>23B. DATE SIGNED</b> <b>11-25-67</b></p>	<p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>E. Hunter Wilson, M.D.</b></p>
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b></p>		<p><b>24B. DATE</b> <b>11/27/1967</b></p>	<p><b>24C. NAME OF CEMETERY or CREMATORY</b> <b>GREENMOUNT CEMETERY</b></p>
<p><b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Md.</b></p>		<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>NOV 28 1967</b></p>	
<p><b>25B. NAME OF REGISTRAR</b> <b>Robert E. Taylor, M.D.</b></p>		<p><b>25C. FUNERAL DIRECTOR</b> <b>Mitchell-Wiedefeld Home 6500 York Rd.</b></p>	

V5153-

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.
67 11388		CERTIFICATE OF DEATH		67 11388
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
KING, SAMSON EDWARD		NOVEMBER 26, 1967 12:25 PM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
ST. AGNES HOSPITAL		A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WILKENS & CATON AVES. BALTIMORE, MD. 21229		MARYLAND 21221 Baltimore		
40		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
		Essex (21) 53-00		
		D. STREET ADDRESS (If rural, give location)		
		850 BRUNSWICK RD.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)
MALE	WHITE	MARRIED	03-07-07	60
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	
MACHINIST		Martin Co.	PENNSYLVANIA	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?	
HARRY KING DEC'D			USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	
NO			207-05-9144	
17. INFORMANT			ADDRESS	
ST. AGNES RECORDS			WILKENS & CATON AVES. - BALTIMORE, MD. 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		
ANTECEDENT CAUSES		(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO		
II		Rheumatoid Arthritis		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		NO		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?		
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 8, 19 67 to NOVEMBER 26, 19 67, that (X) (we) last saw the deceased alive on NOVEMBER 26, 19 67 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXXX) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
(Signature)		11/26/67		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
Federico Pollicina		WILKENS & CATON AVES. ST. AGNES HOSPITAL - BALTIMORE, MD. 21229		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)	
Burial	11/29/67	Holly Hill Memorial Gardens	Baltimore Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS		
NOV 28 1967	(Signature)	Brudzinski Funeral Home 1407 Eastern Ave.		

10:00 AM - 10:15 AM

10:15 AM - 10:30 AM

10:30 AM - 10:45 AM

10:45 AM - 11:00 AM

11:00 AM - 11:15 AM

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11389		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11389	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <i>MARY R. HOPPER</i>		2. DATE AND HOUR OF DEATH <i>11-26-67 12:25 P.M.</i>			
3. PLACE OF DEATH IN <i>Baltimore, Maryland</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>35 Church Home &amp; Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>2008 Gough St.</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>(9/17/1904)</i>	9. AGE (In years last birthday) <i>63</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>HOUSEWIFE</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>JOSEPH BUTKA</i>		14. MOTHER'S MAIDEN NAME <i>ROSE NOVAK</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>-</i>		16. SOCIAL SECURITY NO. <i>216-05-4960</i>		17. INFORMANT ADDRESS <i>Mr. Frank J. Hopper, 2008 Gough Street</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Cancer of Liver. &amp; multiple metastasis.</i>		(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11-22</i> 19 <i>67</i> to <i>11-26</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>11-26</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Rodilio M. Lina</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>11-26-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Rodilio M. Lina</i>		23D. ADDRESS <i>CHH</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/29/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Holy Rosary</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 28 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Jankowski</i>		25C. FUNERAL DIRECTOR <i>M. F. Sadowski &amp; Sons</i>	
				ADDRESS <i>1808 Eastern Ave</i>	

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FUNERAL DIRECTOR: IMPORTANT

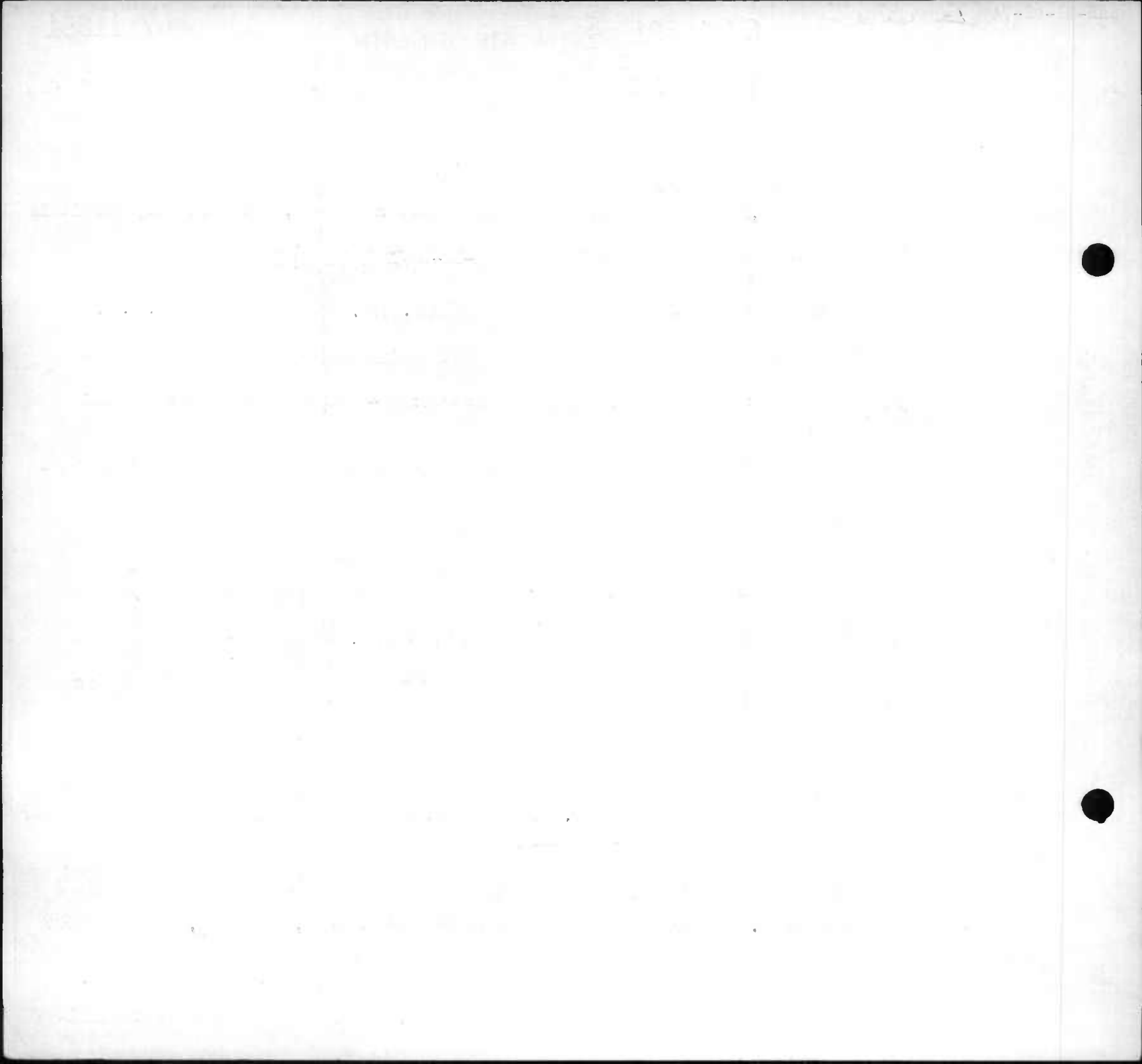
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 11390 CERTIFICATE OF DEATH					Registered No. 67 11390				
BIRTH NO. 67 11390					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <b>DAVID W. BACKOFF</b>					2. DATE AND HOUR OF DEATH <b>Nov. 25/67 1<sup>15</sup> P.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>34 Bon Secours Hospital</b>					A. STATE <b>Md.</b> B. COUNTY				
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>					20-03				
D. STREET ADDRESS (If rural, give location) <b>505 S. pulaski ST.</b>									
5. SEX <b>M.</b>	6. RACE <b>W.</b>	7. MARRIED, <del>NEVER MARRIED</del> WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <b>10-30-60</b>	9. AGE (In years last birthday) <b>7</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Elementary School</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>George Backoff</b>				14. MOTHER'S MAIDEN NAME <b>Golda Backoff SHORT</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Katherine Backoff - 1403 S. Carey St.</b>			
18. <b>03-7-01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Bilateral adrenal hemorrhage</b>					(A) DUE TO				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO <b>Meningococcal meningitis 48 hours</b>				
					(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>2</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>-</b>			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Nov. 24 1967</b> to <b>Nov. 25 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 25 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>A. M. Ghiladi</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11.25/67</b>		
23C. PHYSICIAN'S NAME (Type) <b>Abdolhamid Ghiladi</b>					23D. ADDRESS <b>Bon Secours Hospital</b>				
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>11/28/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Landon Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 28 1967</b>			25B. NAME OF REGISTRAR <b>John E. Fairley</b>			25C. FUNERAL DIRECTOR <b>John J. Cowan 901 Hollins</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 11391		67 11391		67 11391	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print)		ANNA LEE		2. DATE AND HOUR OF DEATH 11/25/67 11:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY		Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		D. STREET ADDRESS (If rural, give location)		4940 Eastern Avenue, Baltimore City Hospitals	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 9-16-1871	9. AGE (In years last birthday) 96	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Home		Home		Balto. Md.	
13. FATHER'S NAME Patirickk Lee		14. MOTHER'S MAIDEN NAME Catherine Karringan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.1 I ASCVD		INTERVAL BETWEEN ONSET AND DEATH unknown			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pernicious Anemia			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 23 1956 to Nov. 25 1967, that (I) (we) last saw the deceased alive on Nov. 25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Raymond J. La Sure		23B. DATE SIGNED 11/25/67			
23C. PHYSICIAN'S NAME (Type) Raymond J. La Sure		23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/28/67		24C. NAME OF CEMETERY or CREMATORY New Cathedral	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 28 1967		25B. NAME OF REGISTRAR R. E. Farley, MD	
25C. FUNERAL DIRECTOR John T. Stansbury		25D. ADDRESS 6411 Windsor Mill Rd			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 11392		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11392	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>BRADLEY MIZZIE</b>				2. DATE AND HOUR OF DEATH <b>11:50 AM 11/25/67</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <b>44 Union Memorial hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3546 BOOLE ST. POOLE</b>			
5. SEX <b>female</b>	6. RACE <b>white</b>	7. <del>MARRIED</del> NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>10/09/1878</b>	9. AGE (In years last birthday) <b>93</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>no</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>no</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>no</b>		12. CITIZEN OF WHAT COUNTRY? <b>Maryland</b>		
13. FATHER'S NAME <b>JESSE LOVELL</b>				14. MOTHER'S MAIDEN NAME <b>HODGES</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Daughter</b> <b>BE P312 BERYL RD</b>	
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>Congestive heart failure</b> (B) <b>hypertensive cardiovascular disease</b> (C) <b>nose bleeding</b>		INTERVAL BETWEEN ONSET AND DEATH <b>11/23/67</b> <b>11/25/67</b> <b>(2 days)</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Nov. 23rd 1967</b> to <b>Nov. 25th 1967</b> , that (I) <u>we</u> last saw the deceased alive on <b>Nov. 25th 1967</b> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <u>did not</u> view the body after death.							
23A. SIGNATURE <b>Rius Y Cho</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>NOV. 25th 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>Rius Y Cho</b>				23D. ADDRESS <b>The Union Memorial Hospital</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/28/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 28 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Paul Elchmann</b>		25D. ADDRESS <b>365 Chestnut Ave</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11393		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11393	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) MRS. LENA PARTLOW			11/24/67 1:30 PM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Merry Hospital Balto. MD.			A. STATE B. COUNTY Balto MD.		
5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto 27-38		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			D. STREET ADDRESS (If rural, give location) 1876 Wadsworths way		
10B. KIND OF BUSINESS OR INDUSTRY			8. DATE OF BIRTH 6/8/08		
13. FATHER'S NAME MR. Eric Partlow			9. AGE (In years last birthday) 59		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			11. BIRTHPLACE (State or foreign country) Danville		
16. SOCIAL SECURITY NO.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
17. INFORMANT ADDRESS			13. MOTHER'S MAIDEN NAME MRS. Rannie Johnson		
18. 583X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) breathing trouble			INTERVAL BETWEEN ONSET AND DEATH 1.5 hours		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Hepatic Coma		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C)		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					
23C. PHYSICIAN'S NAME (Type) PARVIZ KHAJEE AMIO				23D. ADDRESS Merry Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11/27/67		24C. NAME OF CEMETERY or CREMATORY Balto National	
24D. LOCATION (City, town, or county) (State) Balto Md.					
25A. DATE REC'D BY HEALTH DEPT. NOV 28 1967		25B. NAME OF REGISTRAR Paul E. Charon		25C. FUNERAL DIRECTOR 3611 Chestnut Ave	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11394		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11394	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Wilmer Sinkfield</i>		2. DATE AND HOUR OF DEATH <i>11/26/67</i> <i>11 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>		A. STATE <i>MD</i> B. COUNTY <i>BALTO</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTO</i>			
		D. STREET ADDRESS (If rural, give location) <i>1708 LATROBE ST.</i>			
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>3/14/98</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School (Retired)</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Factory</i>		11. BIRTHPLACE (State or foreign country) <i>Pa.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Thos. R. Sinkfield</i>		14. MOTHER'S MAIDEN NAME <i>Sathie Walters</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WWI &amp; II</i>		16. SOCIAL SECURITY NO. <i>215-18-3594</i>		17. INFORMANT <i>Myrtle Harvey</i>	
18. <i>446X I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Septicemia</i> DUE TO		<i>24 hr</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Uremia</i> DUE TO		<i>28 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) <i>Chronic renal failure</i> <i>20 to arteriole nephrosclerosis</i>		<i>years 5</i>	
19A. DATE OF OPERATION <i>10/9/67 + 10/17/67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Polyp ascending colon, paralysis</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>11/20/1967</i> to <i>11/26/1967</i> that (I) (we) last saw the deceased alive on <i>11/26/1967</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Louis E. Gensler</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>11/26/67</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>11/30/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Balto. Nat. Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>NOV 28 1967</i>		25B. NAME OF REGISTRAR <i>R. E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>Wm. P. Chaturman</i>		ADDRESS <i>1701 McCulloch St Balto. Md</i>			

12/12/19

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26/12/19

Uremia

Chronic renal failure  
at the tertiary stage  
marked by uremia  
and azotemia

20x 2-4/10/19

11/1/19 11/1/19

11/1/19

X

11/1/19

James E. Thompson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 11395		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11395	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <b>MARGIE JACKSON</b>				2. DATE AND HOUR OF DEATH <b>Nov. 21, 1967 10 42</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>44 Union Memorial Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give town) <b>27-10</b> D. STREET ADDRESS (If rural, give location) <b>4719 OLD YORK RD.</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>M</b>		8. DATE OF BIRTH <b>2-8-11</b>	9. AGE (In years last birthday) <b>56</b>	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>MISS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>GEO. BUTHER</b> <b>NO INFORMATION</b>				14. MOTHER'S MAIDEN NAME <b>INDIANA KELLEY</b> <b>NO INFORMATION</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT ADDRESS <b>RAYMOND SMITH - 4719 OLD YK. RD.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>331X I</b> <b>Cerebro VASCULAR Accident.</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> <b>Broncho PNEUMONIA</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 21 19 67</b> to <b>Nov 21 19 67</b> , that (I) (we) last saw the deceased alive on <b>Nov 21 19 67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>[Signature]</b> M.D.				23B. DATE SIGNED <b>11/21/67</b>			
23C. PHYSICIAN'S NAME (Type) <b>[Signature]</b>				23D. ADDRESS <b>[Signature]</b> M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/28/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>Brooklyn, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 28 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>William J. Chatman Jr.</b>		25D. ADDRESS <b>1701 McCulloch</b>	

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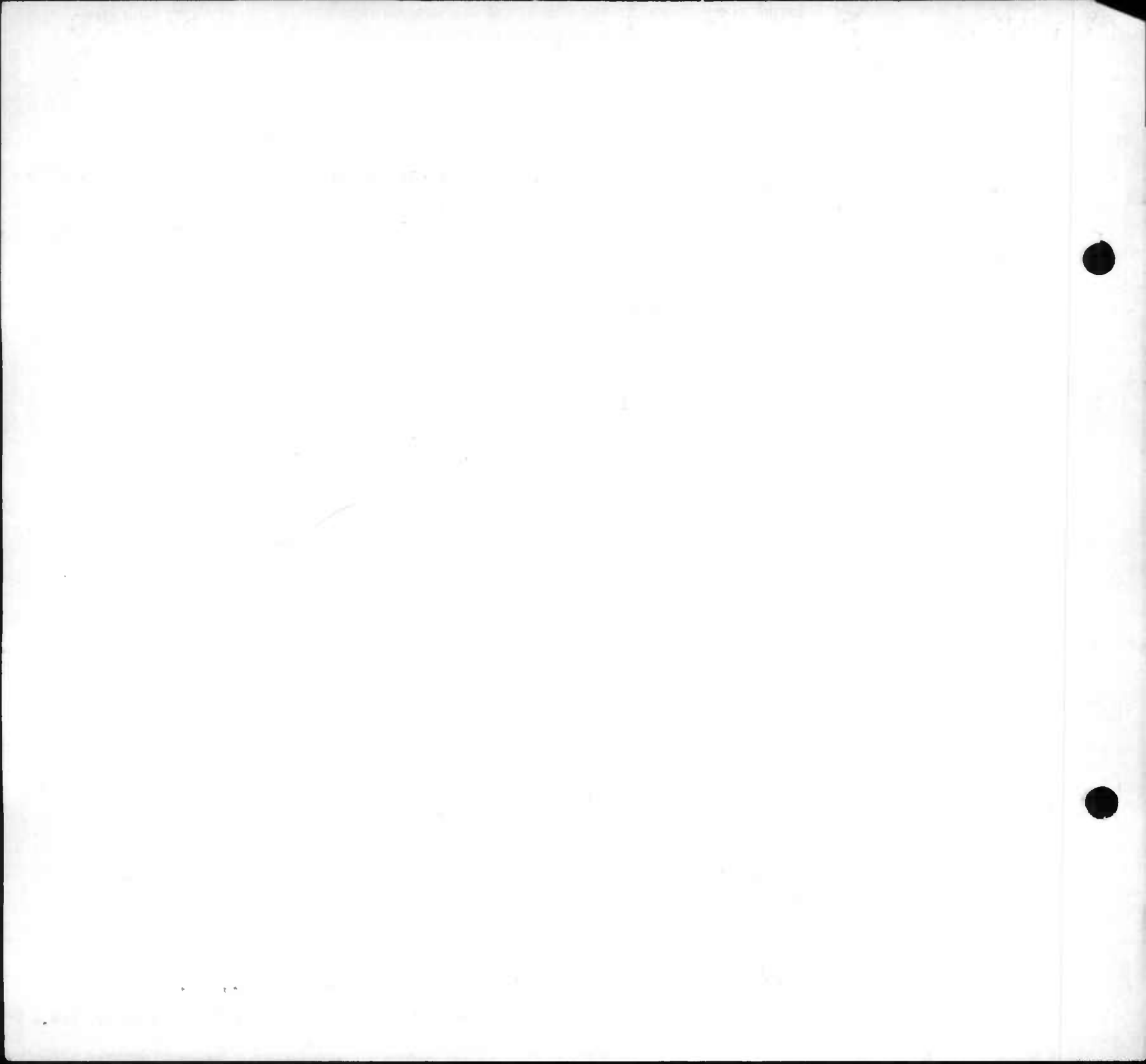
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-600 67 11396 BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 11396	
CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				Jeanette A. Bauer	
2. DATE AND HOUR OF DEATH		11/24/67 2 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Maryland General Hospital		Md. Baltimore			
5. SEX		6. RACE		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
F		W		Middle River 21220 53-00	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		D. STREET ADDRESS (If rural, give location)	
Married		3/21/07		1452 Shore Rd	
9. AGE (In years last birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
60		housewife		Maryland	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Home		USA		George Ott	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Anna Cole		No		217 34 1691	
17. INFORMANT		ADDRESS			
Hospital Chart					
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11/24 19 67 to 11/24 19 67 that (I) (we) last saw the deceased alive on 11/24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
[Signature]				11/24/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		11/27/67		Parkwood Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 28 1967		Robert E. [Signature]		Bruzdzinski Funeral Home	
				ADDRESS	
				1407 Eastern Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. <u>63-23899 67 11397</u>		REGISTERED NO. <u>67 11397</u>	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				(Type or Print) <b>ROBISON, JEFF VERNON</b>		<b>11/23/67 1:30P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>			
<b>ST AGNES HOSPITAL</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
<b>40</b>				D. STREET ADDRESS (If rural, give location) <b>6927 ALTER STREET 07</b>			
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>		8. DATE OF BIRTH <b>08/31/63</b>	
9. AGE (In years last birthday) <b>4</b>		10. AGE (In years last birthday) <b>4</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>none</b>			
13. FATHER'S NAME <b>Paul M. Robison</b>				14. MOTHER'S MAIDEN NAME <b>Susan E. Wight</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Paul M. Robison</b> ADDRESS <b>6927 Alter Street Balto. Md. 21207</b>	
18. <b>474X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) <b>laryngo-tracheitis</b>			
19. ANTECEDENT CAUSES				(B) <b>Spontaneous pneumothorax</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <b>Cardiac arrest</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 23 19 67</b> to <b>NOVEMBER 23 19 67</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 23 19 67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Esther E. Jery</b> M.D.				23B. DATE SIGNED <b>11/23/67</b>			
23C. PHYSICIAN'S NAME (Type) <b>ESTHER E. JERY</b>				23D. ADDRESS <b>ST. AGNES HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/28/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge</b>		24D. LOCATION (City, town, or county) (State) <b>Pikesville Balto. Co. Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 28 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>Loring Byers</b>		ADDRESS <b>8728 Liberty Rd. Randallstown, MD</b>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 11398		67 11398		67 11398	
M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
FOWLER, MARBRA READO		NOVEMBER 25, 1967		8:10A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MARYLAND 21229		MARYLAND 21226			
5. SEX FEMALE		6. DATE OF BIRTH 07-12-01		9. AGE (In years lost birthday) 66	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED		10. BIRTHPLACE (State or foreign country) Piney WEST VIRGINIA		11. CITIZEN OF WHAT COUNTRY? U. S. A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-SAMES CLERK		10B. KIND OF BUSINESS OR INDUSTRY Reads Drug Co.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HOWARD E. LAFFERTY		14. MOTHER'S MAIDEN NAME CORA KEENEY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None	
16. SOCIAL SECURITY NO. 219 26 9664		17. INFORMANT CATON & WILKENS AVES.		18. CAUSE OF DEATH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) mesenteric thrombosis		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. acute dissection of aorta		INTERVAL BETWEEN ONSET AND DEATH	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		21. DATE OF OPERATION Nov. 24, 1967		22. CONDITION FOR WHICH OPERATION WAS PERFORMED intestine obstruction	
23. DATE OF OPERATION Nov. 24, 1967		24. AUTOPSY? (Yes or No) No		25. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
29. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		30. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		31. HOW DID INJURY OCCUR?	
32. I certify that (X) (this hospital) attended the deceased from NOVEMBER 22 19 67 to NOVEMBER 25 19 67 that (X) (we) lost saw the deceased alive on NOVEMBER 25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.		33. SIGNATURE Jaime V. del Pilar		34. DATE SIGNED	
35. PHYSICIAN'S NAME (Type) DR. JAIME V. DEL PILAR		36. ADDRESS CATON & WILKENS AVES., BALTO., MD.		37. ADDRESS 21229	
38. BURIAL CREMATION, REMOVAL (Specify) Burial		39. DATE 11/28/67		40. NAME OF CEMETERY or CREMATORY Cedar Hill	
41. DATE REC'D BY HEALTH DEPT. NOV 28 1967		42. NAME OF REGISTRAR R. E. Fawcett		43. FUNERAL DIRECTOR McCully Funeral Home	
44. ADDRESS 237 Patapsco Ave. 21225		45. ADDRESS 237 Patapsco Ave. 21225		46. ADDRESS 237 Patapsco Ave. 21225	

SALES-CLERK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11399</b>	
BIRTH NO. <b>67 11399</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Hilda M. Kress</b>		2. DATE AND HOUR OF DEATH <b>Nov. 24, 1967</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>90 Gould Convalescarium</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>Gould Convalescarium</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>June 21, 1899</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Librarian</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Enoch Pratt Library</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Nicholas A. Kress</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Donson</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-40-5812</b>		17. INFORMANT <b>Miss Anna Doetsch-3054 Mayfield Ave.-21213</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>350 X I</b> <b>Parkinson Disease</b>		CAUSE OF DEATH (A) DUE TO <b>Parkinson Disease</b> (B) DUE TO <b>Arteriosclerosis, emboli</b> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> <b>10 yrs</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>26 Aug 1950</b> to <b>24 Nov 1967</b> , that (I) (we) last saw the deceased alive on <b>23 Nov 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>27 Nov 67</b>	
23C. PHYSICIAN'S NAME (Type) <b>[Signature]</b>		23D. ADDRESS M.D. <b>864 Harford Rd Baltimore, Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-28-67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>John C. Miller Inc-6415 Belair Rd.-21206</b>			
25D. ADDRESS					

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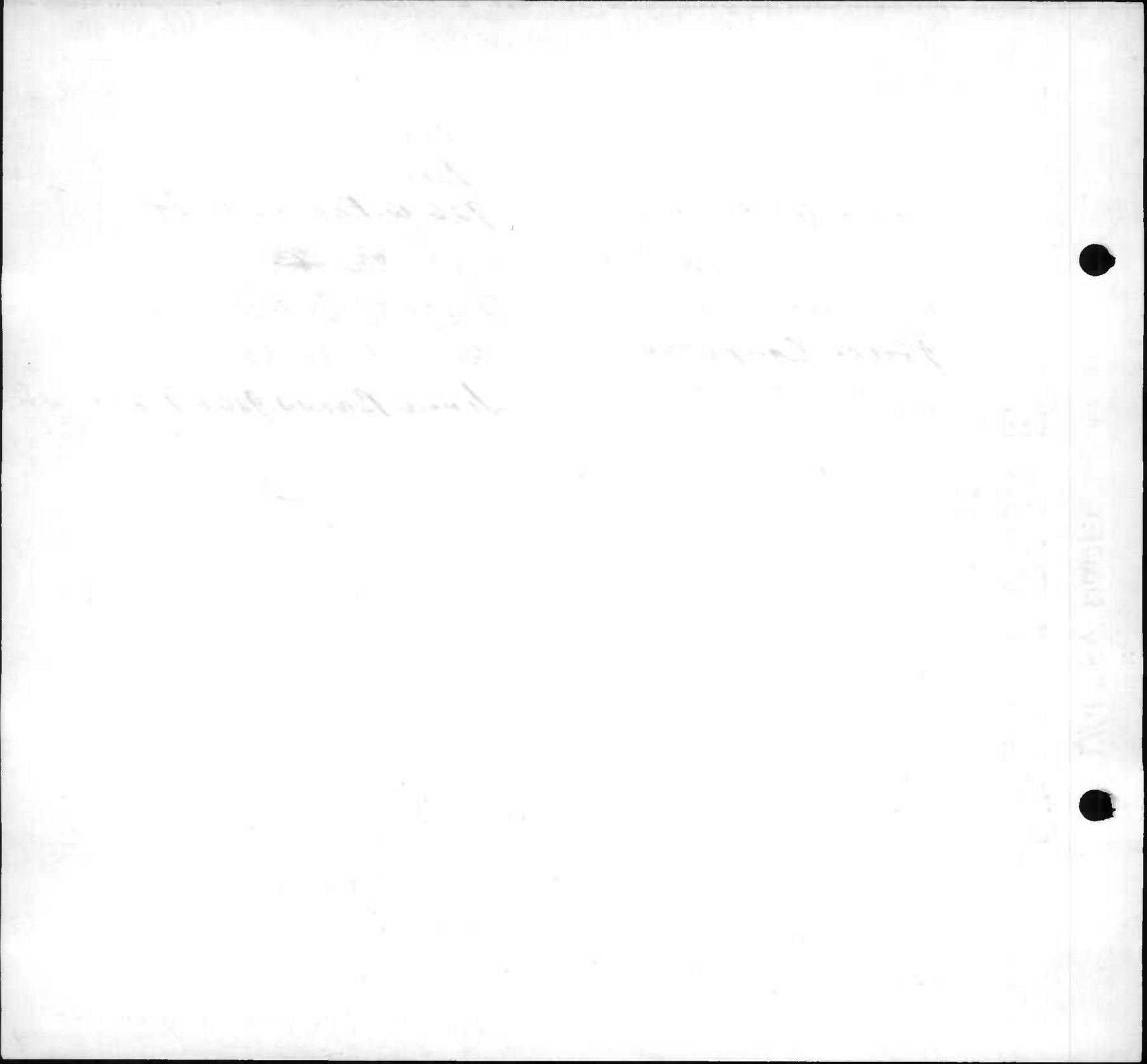
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-653		67 11400		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11400	
<b>CERTIFICATE OF DEATH</b>							
BIRTH NO.				2. DATE AND HOUR OF DEATH			
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <i>Cornelia Bryant.</i>				11/25/67 10 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 La PLAZA Nursing Home. 1515 BRUCE ST BALTO MD 17</i>				A. STATE <i>MD</i>			
				B. COUNTY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE 18-01</i>			
				D. STREET ADDRESS (If rural, give location) <i>926 W. FRANKLIN ST</i>			
5. SEX <i>Fe</i>	6. RACE <i>Myro.</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOW</i>	8. DATE OF BIRTH <i>3-6-1882</i>	9. AGE (In years last birthday) <i>85</i>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>CARVERT CO MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>
13. FATHER'S NAME <i>Peter Campbell</i>			14. MOTHER'S MAIDEN NAME <i>AMELIA HOOKS</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>JENNIE BROWN 926 W. FRANKLIN ST</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>332 XI</i>			CAUSE OF DEATH (A) <i>Cerebral Thrombosis</i> DUE TO (B) <i>Arteriosclerosis.</i> DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH <i>indef.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>11/7 1967</i> to <i>11/25 1967</i> , that (I) (we) last saw the deceased alive on <i>11/25 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Alvin Thompson</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>Alvin Thompson.</i>				23D. ADDRESS <i>1856 N. Wolfe St Balto. 21213.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burn</i>		24B. DATE <i>11/25/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>MT AUBURN</i>		24D. LOCATION (City, town, or county) (State) <i>BALTO MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>NOV 28 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fadden</i>		25C. FUNERAL DIRECTOR <i>Marlene P. Hayes 638 N. Gilman St</i>		ADDRESS	



M-630

67 11401

BALTIMORE CITY HEALTH DEPARTMENT

67 11401

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

BERTHA

MERRITT

2. DATE AND HOUR PRONOUNCED DEAD

November 26, 1967 2:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 1522 Dallas Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1522 Dallas Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SEPARATED

8. DATE OF BIRTH

1/16/1908

9. AGE (In years  
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Lou D. Reddick

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

579-38-8942

17. INFORMANT

ADDRESS

MARY L. McLETT 1522 N. DALLAS ST.

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

11/27/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/30/67

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Balto Maryland

24A. DATE REC'D BY HEALTH DEPT.

NOV 28 1967

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Marshall W. Jones, Jr.

ADDRESS

1735 HARFORD AVE.

1/10/92

Approved

West Coast

Mr. D. R. R.

200-2-1000 Mr. R. R. R.

200-2-1000 Mr. R. R. R.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650		67 11402		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11402	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				BROWN, BENJAMIN SR.		26 NOVEMBER 1967 1 05 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2533 Calverton Heights Avenue 21216			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower	8. DATE OF BIRTH 3-25-1900	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY B+O Railroad		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Brown				14. MOTHER'S MAIDEN NAME Ella Marshall			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 162.1 I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO HYPOXIA, HYPERCAPNIA (B) DUE TO BRONCHOGENIC CARCINOMA (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHRONIC OBSTRUCTIVE Pul. Dis.							
19A. DATE OF OPERATION 21		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 16 NOVEMBER 19 67 to 26 NOVEMBER 19 67. that (I) (we) lost saw the deceased alive on 26 NOVEMBER 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Melvyn S. Tockman M.D.				23B. DATE SIGNED 26 November 1967		23C. PHYSICIAN'S NAME (Type) Melvyn S. Tockman	
23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/29/67		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		24D. LOCATION (City, town, or county) (State) Arbutus, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Tackman		25C. FUNERAL DIRECTOR Kelson Funeral Home		ADDRESS 1348 Calhoun St.	

NOV 28 1967

Mr. J. C. Wood

Marshall

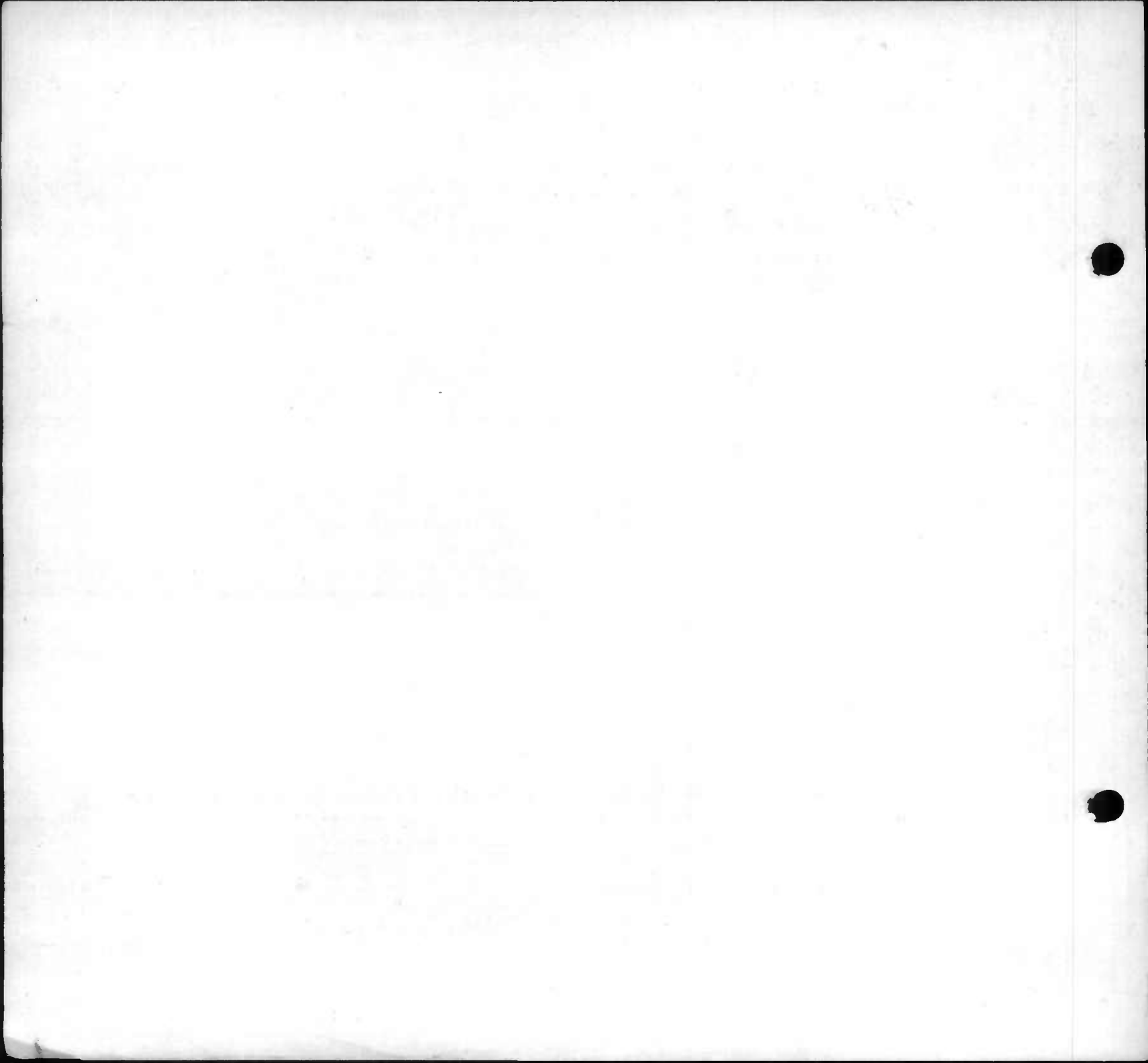
Received of Mr. J. C. Wood the sum of \$100.00

for the sum of \$100.00

FUNERAL DIRECTOR: IMPORTANT

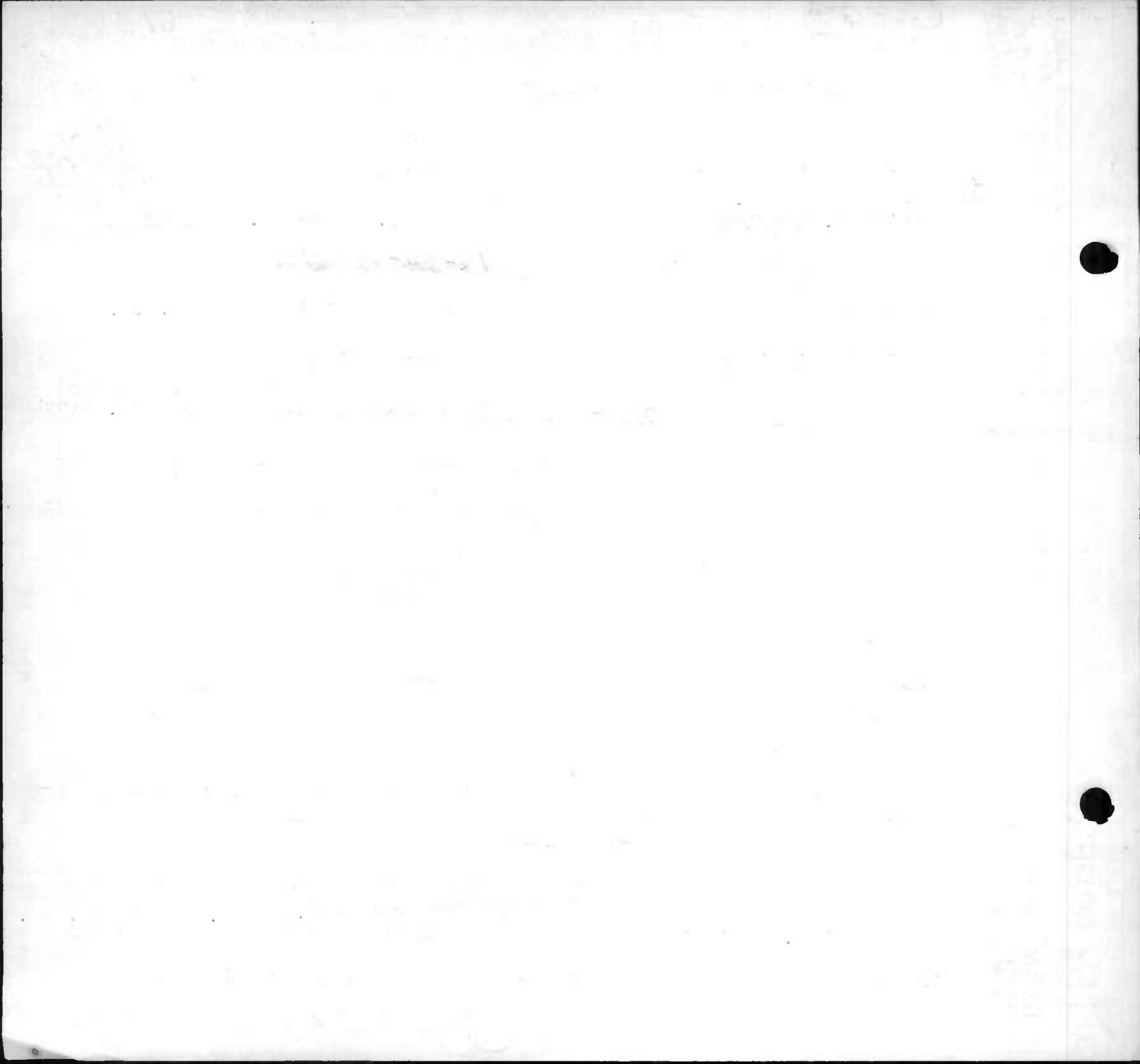
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>67 11403</b>	
BIRTH NO. <b>67 11403</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>HALL JACK</b>		2. DATE AND HOUR OF DEATH <b>11-24-67 2:00 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran hospital, 730, Ashburton Baltimore, MD</b>		A. STATE <b>MD</b> B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 20-07</b>			
		D. STREET ADDRESS (If rural, give location) <b>3305, Elbert St.</b>			
5. SEX <b>Male</b>	6. RACE <b>COLOUR</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>8-10-23</b>	9. AGE (In years last birthday) <b>44</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Monticello, S. Carolina</b>	
13. FATHER'S NAME <b>Willie Hall</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
14. MOTHER'S MAIDEN NAME <b>Lula ?</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>244-183855</b>		17. INFORMANT <b>Mrs. Lula Johnson 4021 Annelan Rd. Balt., Md.</b>	
18. <b>6-18X I</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <b>Empyema.</b>		<b>NOT KNOWN</b>	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>-</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>	
22. I certify that (this hospital) attended the deceased from <b>11-24-67 (1 P.M.)</b> 19 to <b>11-24-67 (2 P.M.)</b> that (we) last saw the deceased alive on <b>11-24-67</b> 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>B.A. DESAI</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-24-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>B.A. DESAI</b>		23D. ADDRESS M.D. <b>Lutheran hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/28/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Neighborhood (Baltimore) Md.</b>					
25A. DATE REC'D BY HEALTH/DEPT. <b>NOV 28 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Joseph L. Davis 2222 N. White Ave Baltimore, Md.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>C-642</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 11404</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>EUGENE CARLOS</b>		2. DATE AND HOUR OF DEATH <b>26 NOVEMBER 1967 2:45 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>10-01</b> D. STREET ADDRESS (If rural, give location) <b>1204 E. Eager St. 21202</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>12-24-12</b>	9. AGE (In years last birthday) <b>54</b>	10. Under 1 Yr. Months Days Hours Min. <b>11 months</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory Worker</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Willie Williams</b>		14. MOTHER'S MAIDEN NAME <b>Selena Carlos</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>249-05-4033</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Baltimore, Maryland</b>		ADDRESS <b>BCH: Records 4940 Eastern Ave. #21224</b>	
18. <b>163X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Lung</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Pancoast Syndrome</b>		CAUSE OF DEATH (A) <b>Carcinoma of Lung</b> DUE TO (B) <b>Pancoast Syndrome</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>11 months</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>26</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>17 August 1967</b> to <b>26 November 1967</b> , that <del>the</del> (we) last saw the deceased alive on <b>26 November 1967</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>Michael R. McMilliam</b> M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/26/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Michael R. McMilliam</b>		23D. ADDRESS <b>4940 Eastern Ave. Baltimore, Md. BALTIMORE CITY HOSPITALS</b>			
24A. BURIAL REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/30/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary</b>	
24D. LOCATION (City, town, or county) <b>A. A. County, Md.</b>		(State)			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 28 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Joseph B. Locks, Jr.</b>	
ADDRESS <b>13047 Central Ave</b>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-253		67 11405		BALTIMORE CITY HEALTH DEPARTMENT		MCCARTHY-11405	
BIRTH NO.		M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) MC CANTS, ELIZABETH				2. DATE AND HOUR OF DEATH 11-26-67 440 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 The Johns Hopkins Hospital 601 N. Broadway Baltimore, Maryland 21205				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 428 Aisquith Street			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH 1/30/22	9. AGE (In years last birthday) 45 yrs.	10. CITIZEN OF WHAT COUNTRY? U.S.A.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		
13. FATHER'S NAME WATKINS, SAM				14. MOTHER'S MAIDEN NAME GRIFFIN, LILLY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Lillie Watson 1210 McCullen Ct.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 441X1 CAUSE OF DEATH (A) cardiac arrests, multiple (B) cerebral edema, probable. (C) malignant hypertension				INTERVAL BETWEEN ONSET AND DEATH 22 hours. 48 hours. 8-12 months.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? If in Baltimore City, give exact location			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11-23-67 to 11-26-67, that (II) (we) last saw the deceased alive on 11-26-67 and that in my (aur) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE Christopher B. Merritt M.D.				23B. DATE SIGNED 11-26-67			
23C. PHYSICIAN'S NAME (Type) Christopher B. Merritt				23D. ADDRESS Johns Hopkins Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/30/67		24C. NAME of CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) A. A. County, Md.	
25A. DATE RECEIVED BY HEALTH DEPT. NOV 28 1967		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Joseph S. North 1304 N. Central Ave.		ADDRESS	

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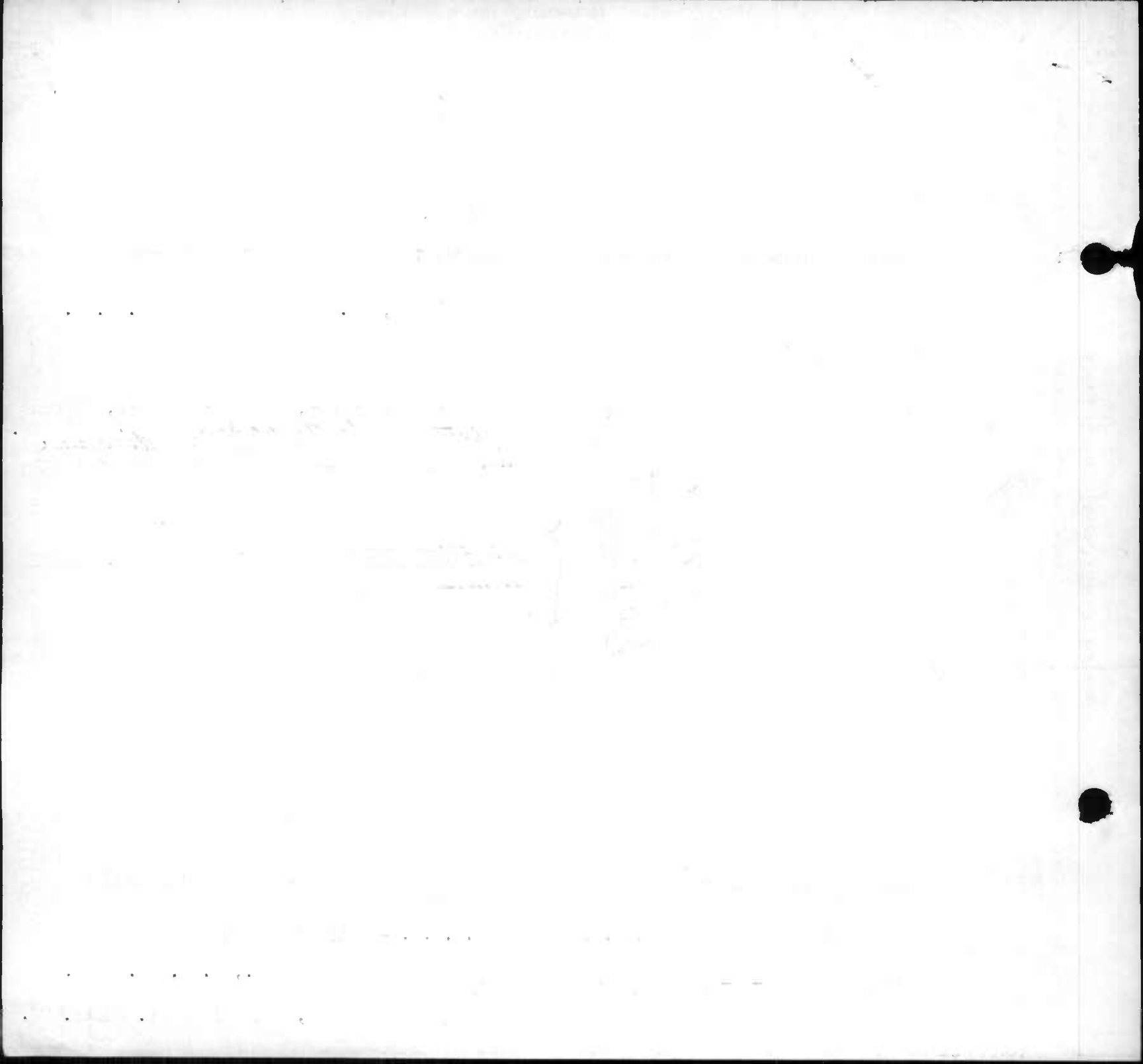
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">67 11406</span>	
BIRTH NO. <span style="font-size: 1.2em;">67 11406</span>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Agnes Folderauer</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">11/26/67</span> <span style="font-size: 1.2em;">10:10</span> p. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">43</span> <span style="font-size: 1.2em;">SOUTH BALTIMORE GENERAL HOSPITAL</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">2402</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">407 E. Clement Street</span>			
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Married</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">5/24/87</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">80</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Baltimore, Md.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U. S. A.</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">Timothy Morann</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Mary Catherine Imhoff</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">None</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Howard Folderauer, 26 Wilfred Court, Towson 4</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  <span style="font-size: 1.2em;">II</span> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH <span style="font-size: 1.2em;">Arteriosclerosis cardio</span> <span style="font-size: 1.2em;">Pulmonary embolism</span> <span style="font-size: 1.2em;">Fracture of left femur</span> <span style="font-size: 1.2em;">and Arteriosclerotic cardiovascular disease</span> <span style="font-size: 1.2em;">Undetermined</span> <span style="font-size: 1.2em;">Fracture of LT. Femur</span> INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">Less than 13 days</span>			
19A. DATE OF OPERATION <span style="font-size: 1.2em;">11-14-67</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">FRACTURE LT. FEMUR</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">Home</span>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <span style="font-size: 1.2em;">407 E. Clement St 30</span>	
21D. TIME OF INJURY (APPROX.) <span style="font-size: 1.2em;">11-13-67- 9.P.M.</span>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <span style="font-size: 1.2em;">Slipped and fell on 3 steps</span>	
22. I certify that (X) (this hospital) attended the deceased from <span style="font-size: 1.2em;">11/13/67</span> 19 to <span style="font-size: 1.2em;">11/26/67</span> 19, that (X) (we) last saw the deceased alive on <span style="font-size: 1.2em;">11/26/67</span> 19 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">John Albert Bigbee</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">11/27/67</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">JOHN ALBERT BIGBEE, M.D.</span>				23D. ADDRESS M.D. <span style="font-size: 1.2em;">S.B.G.H. - 1213 Light Street</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">11-30-67</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Holy Cross Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Ritchie Hwy., A. A. Co. Md.</span>		25A. DATE REC'D. BY HEALTH DEPT. <span style="font-size: 1.2em;">NOV 28 1967</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Flynn &amp; Fleming, 1422 Light St. Balto. Md.</span>			



67 11407

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

67 11407

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

David Widemon

2. DATE AND HOUR OF DEATH

11/25/67

1215 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospital  
4940 Eastern Ave. Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

2616-06

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2815 W. Hanuale St 21216

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

7/10/29

9. AGE (In years  
last birthday)

38

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Davidson Chem.

11. BIRTHPLACE (State or foreign country)

Texas, Austin

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas Widemon

14. MOTHER'S MAIDEN NAME

Alice Widemon

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

unknown

16. SOCIAL  
SECURITY NO.

251-40-6120

17. INFORMANT

ADDRESS

BCH: Records 4940 Eastern Ave. Baltimore, Md. #21224

18. 199-201

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A)  
DUE TO

adenocarcinoma

16 months

primary site unknown

ANTECEDENT CAUSES

(B)  
DUE TODISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(C)  
DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notly medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/23 1967 to 11/25 1967  
that (I) (we) last saw the deceased alive on 11/25 1967 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Harmon J Eyre

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

11/25/67

23C. PHYSICIAN'S  
NAME (Type)

Harmon J Eyre

M.D.

23D. ADDRESS

4940 Eastern Ave. Baltimore, Maryland #21224  
Baltimore City Hosp. Balt. Md.24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial 11-30-67

Balt. Nat'l Cem.

Balto.

Maryland

25A. DATE REC'D BY HEALTH DEPT.

NOV 28 1967

25B. NAME OF REGISTRAR

G. E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Morton E. Dyett F.H. 1701 Laurens St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Archives  
Bureau of  
Education  
1914-1915

1914-1915  
Bureau of  
Education  
1914-1915

67 11408

BALTIMORE CITY HEALTH DEPARTMENT

67 11408

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

SALLY M. PERRY (SALLIE)

2. DATE AND HOUR PRONOUNCED DEAD

November 26, 1967 9:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1628 E. Federal Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1628 E. Federal Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

1-5-1923

9. AGE (In years  
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Warrenton, North Carolina U.S.A.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

JAMES J. ALSTON

14. MOTHER'S MAIDEN NAME

JULIA WILLIAMS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

243-72-9571

17. INFORMANT

Mr. Buck Perry

ADDRESS

1628 E. Federal St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Scleroderma

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

November 26, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

12-2-67

23C. NAME OF CEMETERY or CREMATORY

Shiloh Bapt. Ch. Cem.

23D. LOCATION

Arcola,

(City, town, or county)

North Carolina

(State)

24A. DATE REC'D BY HEALTH DEPT.

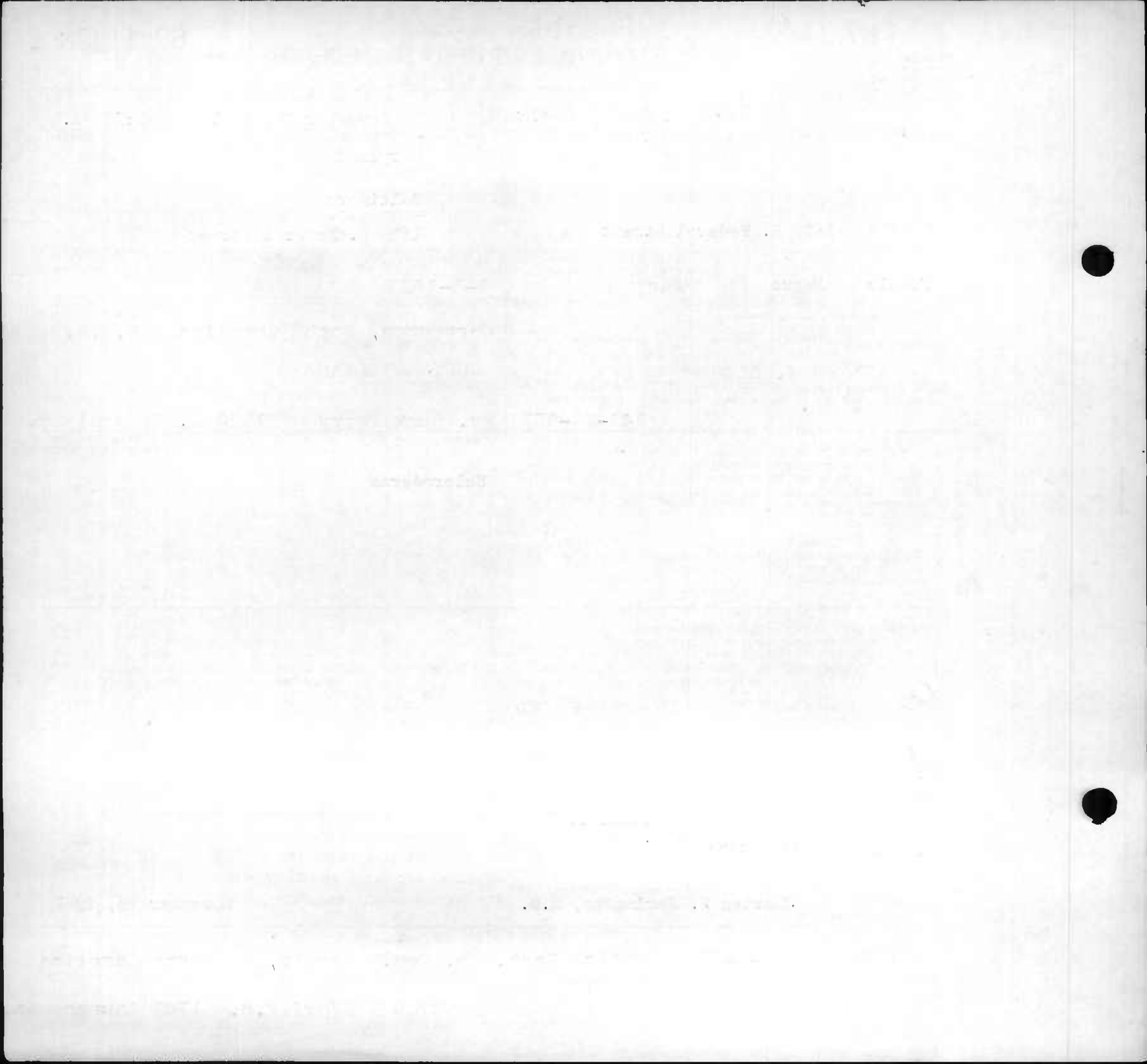
NOV 28 1967

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

MORTON &amp; DYETT F.H. 1701 Laurens St.

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 11409</b>	
BIRTH NO. <b>67 11409</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Alexander Taylor</b>		2. DATE AND HOUR OF DEATH <b>11-26-67 6 P</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>38 University Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Baltimore</b> <b>17-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>614 W. Mulberry St 21201</b>	
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>5-18-1900 67</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cat Washer</b>		10B. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (In years last birthday) <b>67</b>
11. BIRTHPLACE (State or foreign country) <b>N.C.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>	
13. FATHER'S NAME <b>Jerry Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Holloway</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-099092</b>	17. INFORMANT ADDRESS <b>Helen Taylor 617 W. Mulberry St</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of esophagus</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Status post gastrectomy 6 mo.</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>11-17-67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of esophagus</b>	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in car about home, farm, factory, street, office bldg., etc.) _____	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <b>11-8</b> 19 <b>67</b> to <b>11-26</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-26</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Carlos Boetsch</b> M.D.		23B. DATE SIGNED <b>11-26-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr Carlos Boetsch</b> M.D.		23D. ADDRESS <b>University Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/30/1967</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		24D. LOCATION (City, town or county) (State) <b>Cedar Hill Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 28 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>		25D. ADDRESS <b>319 N. Schaefer St</b>	

1900

10

Walter Taylor

Walter Taylor  
1900



A-536

67 11410

BALTIMORE CITY HEALTH DEPARTMENT

67 11410

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

RICHARD Edward ANDERSON

2. DATE AND HOUR PRONOUNCED DEAD

November 26, 1967 3:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1303 N. Calvert Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1303 N. Calvert Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

8-20-1936

9. AGE (In years  
last birthday)

31

If Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Abilene, Texas

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edward Ewell Anderson

14. MOTHER'S MAIDEN NAME

Polly Anne Bates

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

Unknown

17. INFORMANT

Charles A. Logan, St. 612 E. 34th St.  
21218

18.

E-977X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Exsanguination Due to Slash Wounds Of  
XXXXXX Neck

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

1303 N. Calvert Street

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
11/26/67 11:00 A.  
3:00 P.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Slashed throat

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/27/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/29/1967

23C. NAME OF CEMETERY or CREMATORY

Meadowridge Mem.

23D. LOCATION

(City, town, or county)

Anne Arundel Co. Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

NOV 28 1967

11/28/67, J. J. J.

Wm. Cook-Brooks, Inc.

1217 St. Paul St.  
Baltimore, Md.

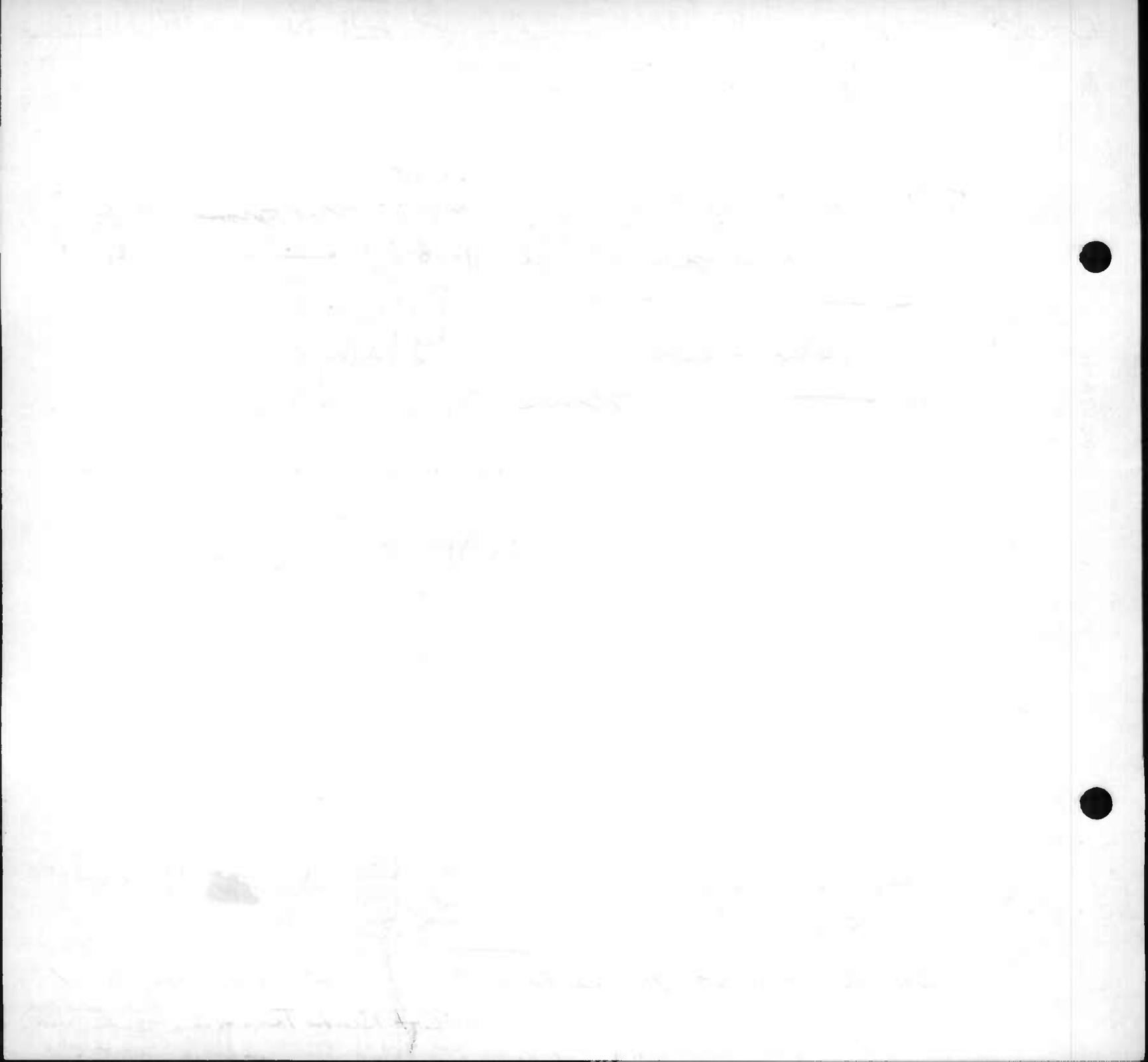
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>67-24175</u> <u>67 11411</u> <b>CERTIFICATE OF DEATH</b>				Registered No. <u>67 11411</u> <u>4</u>	
1. NAME OF DECEASED (Type or Print) <u>John <del>James</del> ANN MARIE</u>				2. DATE AND HOUR OF DEATH <u>11-26-67</u> <u>11:36</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>42 Sinai Hosp</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>—</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hosp</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>21215</u>	
D. STREET ADDRESS (If rural, give location) <u>4905 Chalgrave Ave</u>				5. SEX <u>F</u> 6. RACE <u>Caucasian</u> 7. MARRIED/NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never Married</u>	
8. DATE OF BIRTH <u>11-26-67</u> 9. AGE (In years last birthday) <u>—</u>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dr. George Ordover</u>				14. MOTHER'S MAIDEN NAME <u>Lady's — Ordover</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Dr. Sam LeBauer</u>				ADDRESS <u>Sinai Hosp</u>	
18. <u>73301</u> CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac Arrest</u>				<u>9 hrs.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Aspiration Pneumonia</u>				<u>45 min</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>(?)</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11-26-67</u> 19 <u>67</u> to <u>11-26</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-26-67</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> did not view the body after death.					
23A. SIGNATURE <u>Sam LeBauer</u>				23B. DATE SIGNED <u>11-26-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Sam LeBauer</u>				23D. ADDRESS <u>Sinai Hosp</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-27-67</u>		24C. NAME OF CEMETERY & CREMATORY <u>New Cathedral</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 28 1967</u>			
25B. NAME OF REGISTRAR <u>Robert S. Taylor</u>		25C. FUNERAL DIRECTOR <u>Wm Cook Brooks Towson Inc</u>			
25D. ADDRESS <u>1050 York Rd Towson Md.</u>		25E. <u>21204</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <b>67 11412</b>		
67 11412 CERTIFICATE OF DEATH												
BIRTH NO. <b>67 11412</b>					M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <b>LYDA I. Hopwood</b>					2. DATE AND HOUR OF DEATH <b>11-25-67 1:20 A.M.</b>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hosp.</b>					A. STATE <b>md.</b>							
					B. COUNTY <b>BALTO.</b>							
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO.</b>					D. STREET ADDRESS (If rural, give location) <b>G32 GORSUCH AVE.</b>							
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>			8. DATE OF BIRTH <b>10-2-84</b>	9. AGE (In years last birthday) <b>83</b>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>?</b>					14. MOTHER'S MAIDEN NAME <b>?</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>					16. SOCIAL SECURITY <b>218-18-2552</b>		17. INFORMANT <b>HOWARD Hopwood</b>			ADDRESS <b>AS ABOVE.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) <b>generalized sepsis</b> (B) <b>ASCUD</b> (C) <b>?</b>					INTERVAL BETWEEN ONSET AND DEATH <b>~2 mos.</b>		
19A. DATE OF OPERATION <b>9-24-67</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fractured Hip</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>9-24 1967</b> to <b>11-25 1967</b> , that (I) (we) last saw the deceased alive on <b>11-25 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.												
23A. SIGNATURE <b>Frank S. Palmisano</b> M.D.										23B. DATE SIGNED <b>11-25-67</b>		
23C. PHYSICIAN'S NAME (Type) <b>FRANK S. PALMISANO JR</b>					23D. ADDRESS M.D. <b>THE UNION MEMORIAL HOSPITAL</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>11/28/67</b>		24C. NAME of CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 28 1967</b>			25B. NAME OF REGISTRAR <b>Robert E. Farley</b>			25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks, Inc.</b>			ADDRESS <b>1217 St. Paul St.</b>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11413		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11413	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SAVINA MARIE LOWTHER		2. DATE AND HOUR OF DEATH 11-25-67	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore		5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSP.		6. STREET ADDRESS (If rural, give location) 7906 UNDERHILL RD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-17-1911	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROOF READER		10B. KIND OF BUSINESS OR INDUSTRY PRINTING		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOHN HEINER		14. MOTHER'S MAIDEN NAME UNKNOWN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT H. Henry B. Lowther - 7906 Underhill Rd.		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.11-220X Disease or Condition Directly Leading to Death		CAUSE OF DEATH Acute Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 9	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Astherosclerosis Heart Disease		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO Diabetes Mellitus			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 4 1967 to Nov 4 1967, that (I) (we) last saw the deceased alive on Nov 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. D.O.A. J.H.H. Nov. 25-67					
23A. SIGNATURE V. S. ADARANDH		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/27/67	
23C. PHYSICIAN'S NAME (Type) V. S. ADARANDH		23D. ADDRESS 6801 Belair Rd, Balto 6 Md			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-28-67		24C. NAME of CEMETERY or CREMATORY OAK LAWN CEMETERY	
24D. LOCATION BALTO., MD.		25A. DATE REC'D BY HEALTH DEPT. NOV 28 1967			
25B. NAME OF REGISTRAR P. E. Jackson		25C. FUNERAL DIRECTOR Gentry Miller - 2334 Jefferson St			

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Naomi

ROBINSON

2. DATE AND HOUR PRONOUNCED DEAD

November 25, 1967 8:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
HOSPITAL OR ADDRESS OR LOCATION)  
INSTITUTION

35 Church Home and Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1409 Tin Pan Alley

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Widowed

8. DATE OF BIRTH

5/9/1900

9. AGE (In years  
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Packing House

11. BIRTHPLACE (State or foreign country)

Pickens CO. S. C.

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Lucius Robinson

14. MOTHER'S MAIDEN NAME

Anna Kirksey

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

216-20-9456

17. INFORMANT

ADDRESS

Mrs Texie Anne Jones-2717 Rosedale Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Cerebrocranial injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Baltimore and Dallas Streets

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
11-24-67 4:00 P.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian hit by truck

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-25-67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/30/67

23C. NAME OF CEMETERY or CREMATORY

Mt. Olive Cemetery

23D. LOCATION

(City, town, or county)

(State)

Greenville South Carolina

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

NOV 28 1967

Robert E. Farkner

Herbert E. Nutter 3035 W. North Ave.

100

100

100

100

100

100

100

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11415				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11415	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Marcus Bell</b>				2. DATE AND HOUR OF DEATH <b>11/20/67 10:50 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>37 Mercy Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2131 Homewood Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>2/5/1880</b>	9. AGE (In years lost birthday) <b>87</b>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Canning Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Lynchburg VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick Bell</b>				14. MOTHER'S MAIDEN NAME <b>Virginia Lewis</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-12-9796A</b>		17. INFORMANT ADDRESS <b>Mrs Rebecca Miller 2131 Homewood Ave.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>493X1</b> <b>Pneumococcal meningitis ? 3 days</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>11/20/67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Tracheotomy</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11/20</b> 19 <b>67</b> to <b>11/20</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11/20</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Louis E. Grenzer</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/21/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Louis E. Grenzer</b>		23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/25/67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, CO. Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 28 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Herbert E. Nutter 3035W. North Ave.</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-143 67 11416		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 11416	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BOBLITZ HARRY</b>	
2. DATE AND HOUR OF DEATH <b>NOVEMBER 25 1967 4:35A</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>ST AGNES HOSPITAL</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>40 CATON &amp; WILKENS AVE. BALTIMORE MD 21229</b>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>PASADENA MARYLAND</b> B. COUNTY <b>ANNE ARUNDEL</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>PASADENA 52-00</b> D. STREET ADDRESS (If rural, give location) <b>RT 1 BOX 23 (LAKE SHORE)</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>11/6/28 89</b>	9. AGE (In years lost, birthday) <b>78</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>		11. BIRTHPLACE (State or foreign country) <b>(BALTIMORE) MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>WILLIAM H. BOBLITZ</b>		
14. MOTHER'S MAIDEN NAME <b>MARY CREAMER</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>WW1</b>		
16. SOCIAL SECURITY NO. <b>218-10/8110</b>			17. INFORMANT <b>ST AGNES RECORDS CATON &amp; WILKENS</b>		
18. ADDRESS <b>AVENUE S</b>			19. CAUSE OF DEATH <b>Carcinoma of Esophagus with Tracheo-bronchial fistula</b>		
20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>			21. INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>XX</b> (this hospital) attended the deceased from <b>NOVEMBER 9 1967</b> to <b>NOVEMBER 25 1967</b> , that <b>X</b> (we) last saw the deceased alive on <b>NOVEMBER 25 1967</b> and that in <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ramon Suarez</b>				23B. DATE SIGNED <b>11-25-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. RAMON SUAREZ</b>				23D. ADDRESS <b>CATON &amp; WILKENS AVES. BALTIMORE, MARYLAND 21229</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>Nov. 28/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTIMORE NATIONAL CEM. BALTIMORE, MARYLAND</b>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 28 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>Singleton Funeral Home</b>		25D. ADDRESS <b>Glen Burnie, Maryland</b>	



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type) **PERRY** **MITCHELL** 2. DATE AND HOUR PRONOUNCED DEAD  
**November 20, 1967** **11:15 P.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
**Maryland** A. STATE B. COUNTY

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore**

D. STREET ADDRESS (If rural, give location)  
**132 W. 25th Street**

5. SEX **Male** 6. RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **NEVER MARRIED** 8. DATE OF BIRTH **3 1952** 9. AGE (In years last birthday) **15** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) **Boston, Mass.** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **JOHN MITCHELL** 14. MOTHER'S MAIDEN NAME **DOROTHY**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **No** 16. SOCIAL SECURITY NO. **—** 17. INFORMANT **MIKE MITCHELL, 925 So Plymouth St., ARLINGTON, Va.** ADDRESS

18. **E982X** CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) **Stabwound of Chest, involving heart, XXXXX lung, and aorta**

ANTECEDENT CAUSES  
 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **2** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) **Yes** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **Yes**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **Home** 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **132 W. 25th Street**

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) **11/20/67 10:50 P.** 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? **subj. stabbed during altercation**

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE **Werner U. Spitz** M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **11/21/67**  
 EXAMINER'S NAME (Type) **Werner U. Spitz, M.D.** ASSISTANT MEDICAL EXAMINER ☒  
 ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **Nov 24/1967** 23C. NAME OF CEMETERY or CREMATORY **Wm. Oliver Home** 23D. LOCATION (City, town, or county) (State) **Washington D.C.**

24A. DATE REC'D BY HEALTH DEPT. **NOV 28 1967** 24B. NAME OF REGISTRAR **Robert E. Farkas** 24C. FUNERAL DIRECTOR **J. Farkas** ADDRESS **550 WASH Blvd LAUREL, Md.**

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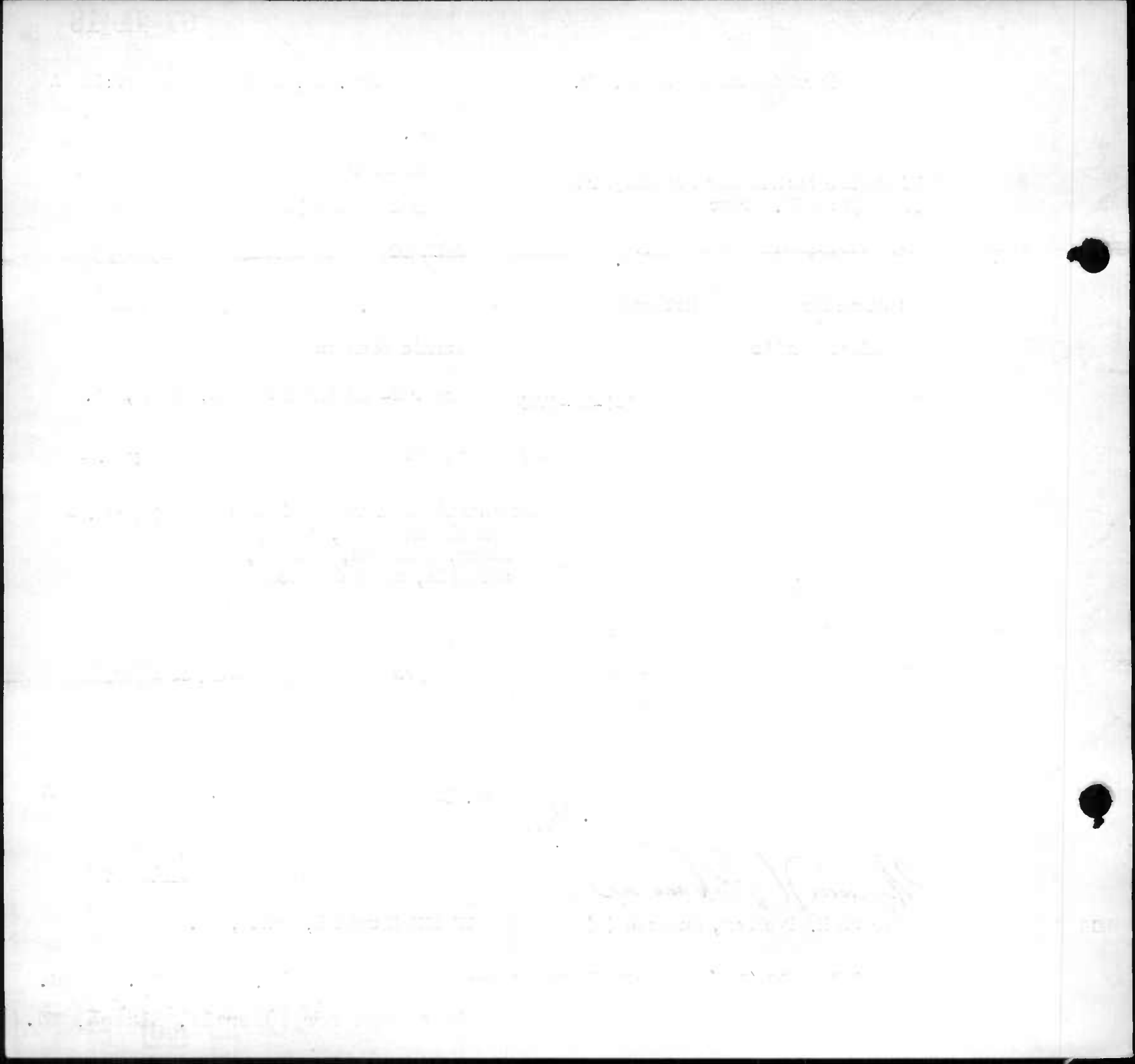
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>5-312</b>		67 11418		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 11418</b>	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Harold Steele Stubbs, Sr.</b>				Nov. 16, 1967		5:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>US Public Health Service Hospital 3100 Wyman Pk. Drive</b>				A. STATE <b>Md.</b> B. COUNTY <b>Cecil Co.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>RD 2 Box 316</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Div.</b>	8. DATE OF BIRTH <b>6/21/90</b>	9. AGE (In years lost birthday) <b>77</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Stubbs</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Boulden</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-16-4753</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>			
18. <b>190.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinomatosis</b> (A) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs. 4</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Metastatic malignant melanoma involving lungs, heart, liver, pancreas, spleen, adrenals, stomach &amp; bone</b> (B) DUE TO (C) DUE TO				<b>3 yrs. 4</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Oct. 31</b> 19 <b>67</b> to <b>Nov. 16</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Nov. 16</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Norman H. Pwckham, Surgeon (R)</b>						23B. DATE SIGNED <b>11/16/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Norman H. Pwckham, Surgeon (R)</b>		23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/19/67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Bethel, Cecil Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 28 1967</b>		25B. NAME OF REGISTRAR <b>R. E. Farley</b>		25C. FUNERAL DIRECTOR <b>Ralph E. Nick</b> Hicks Home for Funerals, Elkton, Md.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-324		67 11419		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11419	
BIRTH NO. M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)			
				Harry Mitchell			
2. DATE AND HOUR OF DEATH				22 Nov 67 6 <sup>00</sup> a. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Fayette Convalescent Home				A. STATE Maryland			
				B. COUNTY Baltimore			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 4402 Shamrock Ave 21206			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE		8. DATE OF BIRTH 19 Feb 93	9. AGE (In years last birthday) 74	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND USA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME E.C. Mitchell				14. MOTHER'S MAIDEN NAME ELIZABETH KALINE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 218-02-2956		17. INFORMANT Howard Richmond	
				ADDRESS 4402 Shamrock Ave 21206			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Chronic Obstructive Airway Dis. DUE TO (B) ASCVD DUE TO (C) —			
				INTERVAL BETWEEN ONSET AND DEATH 2 mo indef.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Cereb. ASCVD indef.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 31 July 1967 to 22 Nov 1967, that (I) (we) lost saw the deceased alive on 22 Nov 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE J. Hulla				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 22 Nov 67	
23C. PHYSICIAN'S NAME (Type) J. Hulla				23D. ADDRESS 2214 E Fayette St		21201	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-24-67		24C. NAME of CEMETERY or CREMATORY PARKWOOD CEMETERY		24D. LOCATION (City, town, or county) (State) BALTO. CO., MD.	
25A. DATE REC'D BY HEALTH DEPT. NOV 28 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR WILLIAM FUNERAL HOME		ADDRESS 4210 BELAIR	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<b>W-322</b> <b>67 11420</b> <b>BALTIMORE CITY HEALTH DEPARTMENT</b>		<b>CERTIFICATE OF DEATH</b>		Registered No. <b>67 11420</b>	
BIRTH NO. <b>W-322</b> <b>67 11420</b>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>WATCHESKI, CARROLL</b>			2. DATE AND HOUR OF DEATH <b>11/27/67</b> <b>5.25 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>46 LUTHERAN HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>53-00</b> <b>2927 ILLINOIS AVE. 21</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Oct. 1 1912</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months: Days:      If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tavern Opt.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
13. FATHER'S NAME <b>Frank Watcheski</b>			14. MOTHER'S MAIDEN NAME <b>Anna Gotzke</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>21305 1131</b>		17. INFORMANT <b>Mary Watcheski</b> ADDRESS <b>2927 Illinois Ave</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>PNEUMONIA</b>			CAUSE OF DEATH <b>PNEUMONIA</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<b>CARCINOMA OF ESOPHAGUS</b> <b>MONTHS</b>		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/6</b> 19 <b>67</b> to <b>11/27</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11/27</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>F. Queral</b>				23B. DATE SIGNED <b>11/27/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>F. QUERAL</b>				23D. ADDRESS <b>LUTHERAN HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Nov. 30-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Cross</b>	
24D. LOCATION (City, town, or county) (State) <b>German Hill Rd. Balto. Co Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 28 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jankowski</b>		25C. FUNERAL DIRECTOR <b>Doppel Bros Inc. 1800 E. Lombard St 31</b>			

LUTHERAN HOSPITAL

2427 ILLINOIS AVE

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CHICAGO, ILL.

CHICAGO, ILL.

PNEUMONIA

CARCINOMA OF ESOPHAGUS

F. GUERIN

F. GUERIN

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LUTHERAN HOSPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>H-650</b>      <b>67 11421</b>      <b>CERTIFICATE OF DEATH</b>      Registered No. <b>67 11421</b></p>	
<p>BIRTH NO. <b>67 11421</b></p>	
<p>M.E. CASE NO.</p>	
<p>1. NAME OF DECEASED (Type or Print) <b>GEORGE W. HORN</b></p>	
<p>2. DATE AND HOUR OF DEATH <b>11/27/67 7:40 P.M.</b></p>	
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p>	
<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)</p>	
<p>A. STATE <b>Md.</b> B. COUNTY</p>	
<p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO. 21212</b></p>	
<p>D. STREET ADDRESS (If rural, give location) <b>1427 MERIDENE DR.</b></p>	
<p>5. SEX <b>M.</b> 6. RACE <b>W.</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b></p>	
<p>8. DATE OF BIRTH <b>06/08/99</b> 9. AGE (In years last birthday) <b>68</b></p>	
<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Butcher</b></p>	
<p>10B. KIND OF BUSINESS OR INDUSTRY <b>Meat Markets</b></p>	
<p>11. BIRTHPLACE (State or foreign country) <b>BALTO. Md.</b></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>	
<p>13. FATHER'S NAME <b>DAVID HORN</b></p>	
<p>14. MOTHER'S MAIDEN NAME <b>Amanda MARKIEWICZ</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>	
<p>16. SOCIAL SECURITY NO. <b>215-18-7226A</b></p>	
<p>17. INFORMANT ADDRESS <b>LOUISE HORN wife same</b></p>	
<p>18. CAUSE OF DEATH</p>	
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Cardiac arrest ?</b></p>	
<p>ANTECEDENT CAUSES <b>Myocardial infarction</b></p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	
<p>19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <b>X</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED <b>While At Work</b> 21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>11/27 11/07</b> 19 <b>67</b> to <b>11/27</b> 19 <b>68</b>, that (I) (we) last saw the deceased alive on <b>11/27</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>	
<p>23A. SIGNATURE <b>A. N. Markiewicz</b> M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> 23B. DATE SIGNED <b>11/27/67</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>A. N. MARKIEWICZ</b> M.D. 23D. ADDRESS <b>Rd. GENERAL Hosp.</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b> 24B. DATE <b>11/30/67</b> 24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b> 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>NOV 28 1967</b> 25B. NAME OF REGISTRAR <b>Robert E. Farley</b> 25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b></p>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>R-200</b>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 11422</b>	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>RAEKE, CATHERINE E.</b>				2. DATE AND HOUR OF DEATH <b>NOVEMBER 27, 1967 3:00P M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>40 ST. AGNES HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city (limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>25-52 1005 DE SOTA ST. 21230</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>2-18-01</b>		9. AGE (In years last birthday) <b>66</b>	10. (If Under 1 Yr. Months; Days; If Under 24 Hrs. Hours; Min.)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>CHARLES WAKEFIELD</b>				14. MOTHER'S MAIDEN NAME <b>LOUISA STEIN WAKEFIELD</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NONE</b>			16. SOCIAL SECURITY NO. <b>213-05-9179</b>		17. INFORMANT ADDRESS <b>ST. AGNES HOSPITAL RECORDS</b>		
18. <b>733,11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Multiple Thrombo Embolic Dis.</b>				CAUSE OF DEATH (A) <b>Congestive Heart Failure</b> DUE TO (B) <b>Atrial fibrillation -</b> DUE TO (C) <b>A.S.E.D.</b>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 14 19 67</b> to <b>NOVEMBER 27 19 67</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 27 19 67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Alejandro Mejia</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/27/67.</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALEJANDRO MEJIA</b>				23D. ADDRESS M.D. <b>BALTO, MD 21229 ST. AGNES HOSP; CATON-WILKENS AVES.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/30/67.</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 28 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairley</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.</b>		ADDRESS <b>Balto. Md. 21214</b>	

IN RE: CARROLL E.

1942-43

REVENUE

1942-43

1942-43

LAND

LOUISA STEIN WARE

215-22-2176 ST. ANNE'S HOSPITAL

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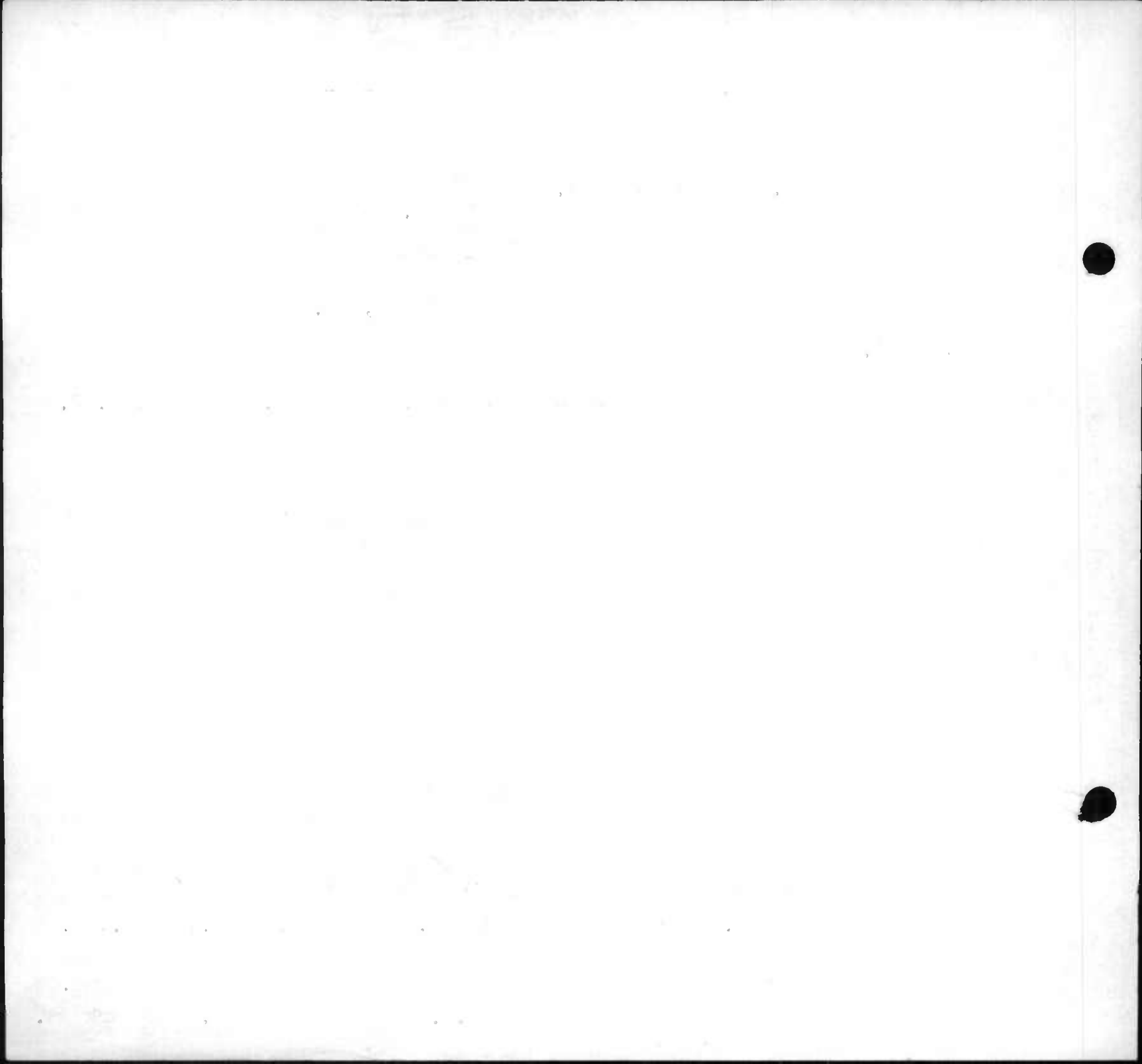
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FUNERAL DIRECTOR: IMPORTANT

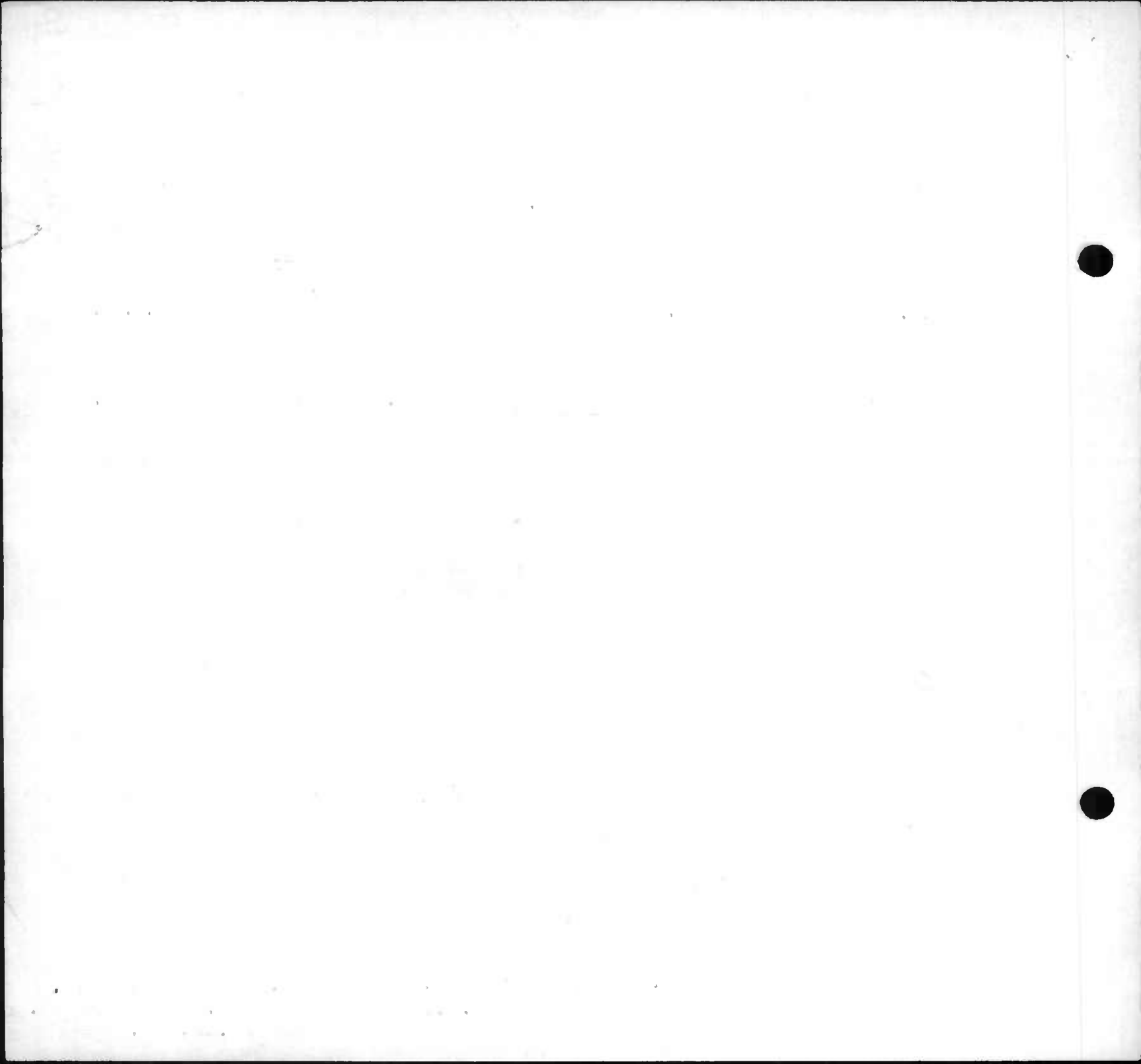
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 11423		67 11423	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
JOHN E. SEMMES			11-26-67 12:30 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
00 100 W. University Pkwy.			Maryland		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			100 W. University Parkway		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
M	W	Married	4-15-1881	86	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Lawyer		Law	Baltimore, Md.		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John E. Semmes			Frances Hayward		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
Yes WW 1		215-40-9176	John E. Semmes Jr. Summit, N. J.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
334 XI		Pneumonia		2 days	
ANTECEDENT CAUSES		Arteriosclerosis, general		2 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C) DUE TO	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 11/6/67 to 11/26/67, that (II) (we) last saw the deceased alive on 11/25/67 and that in my (aur) opinion death occurred on the date and hour and from the causes stated above. (II) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Francis W. Gluck				11/27/67	
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Francis W. Gluck			100 W. University Pkwy., Balto., Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Cremation		11-27-67		Greenmount	
				Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 28 1967		Robert E. Jenkins		H.W. Jenkins & Sons Co. 4905 York Rd.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>87 11424</b>	
BIRTH NO. <b>67 11424</b>		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Stone, John Bradley</b>		<b>11/23/67 10:20 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Bolton Hill Nursing &amp; Convalescent Ctr.</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>13-05</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>9/2/74</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>R.R. Engineer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Pa. Railroad</b>	9. AGE (In years last birthday) <b>93</b>
13. FATHER'S NAME <b>Bradley Nelson Stone</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>717-07-8760</b>	
17. INFORMANT <b>Luther B. Stone, 402 Radnor Ave.</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Coronary Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>arteriosclerosis</b> (C) <b>arteriosclerosis, C.V. disease, arteriosclerosis, generalized</b>	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21A. TIME OF INJURY (Month) (Day) (Year) (Hour)		21B. INJURY OCCURRED	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>11/16</b> 19 <b>65</b> to <b>11/23</b> 19 <b>67</b> , that (1) (we) last saw the deceased alive on <b>11/23</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>ALLAN H. MACHT</b> M.D. 23B. DATE SIGNED <b>11/24/67</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/29/67</b>	
24C. NAME OF CEMETERY or CREMATORY <b>St. Mary's Church Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Hampden, Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 28 1967</b>		25B. NAME OF REGISTRAR <b>H.W. Jenkins &amp; Sons Co.</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11425

CERTIFICATE OF DEATH

Registered No.

67 11425

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ANNA B. MERLE

2. DATE AND HOUR OF DEATH

11-27-67 11:15 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(If not in hospital or institution, give street  
address or location)

37 MERCY HOSPITAL, INC.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE 27-14

D. STREET ADDRESS (If rural, give location)

401 OVERHILL RD.

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

9-4-79

9. AGE (In years  
last birthday)

88

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOMEMAKER

10B. KIND OF BUSINESS OR INDUSTRY

OWN HOME

11. BIRTHPLACE (State or foreign country)

BALTIMORE, Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

FREDERICK WIPPERT

14. MOTHER'S MAIDEN NAME

MARIE ZIER

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

216-46-3223

17. INFORMANT

ANDREW W. MERLE, JR.

ADDRESS

1003 BOYCE AVE. 21204

18.

4-20-1 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

(B) DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

unknown

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTO? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work

Not While  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from November 16 1965 to November 27 1967, that (I) (we) lost saw the deceased alive on November 27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Bayani L. Manalo

M.D.

Attending  
Phys.

Med.  
Director

Stoff  
Phys.

✓

23B. DATE SIGNED

11-27-67

23C. PHYSICIAN'S  
NAME (Type)

BAYANI L. MANALO

M.D.

23D. ADDRESS

MERCY HOSPITAL, BALTO - MD - 21202

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Entombment

24B. DATE

11/30/67

24C. NAME OF CEMETERY or CREMATORY

Lorraine Park Mausoleum

24D. LOCATION

(City, town, or county)

(State)

Woodlawn, Baltimore County, Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 28 1967

25B. NAME OF REGISTRAR

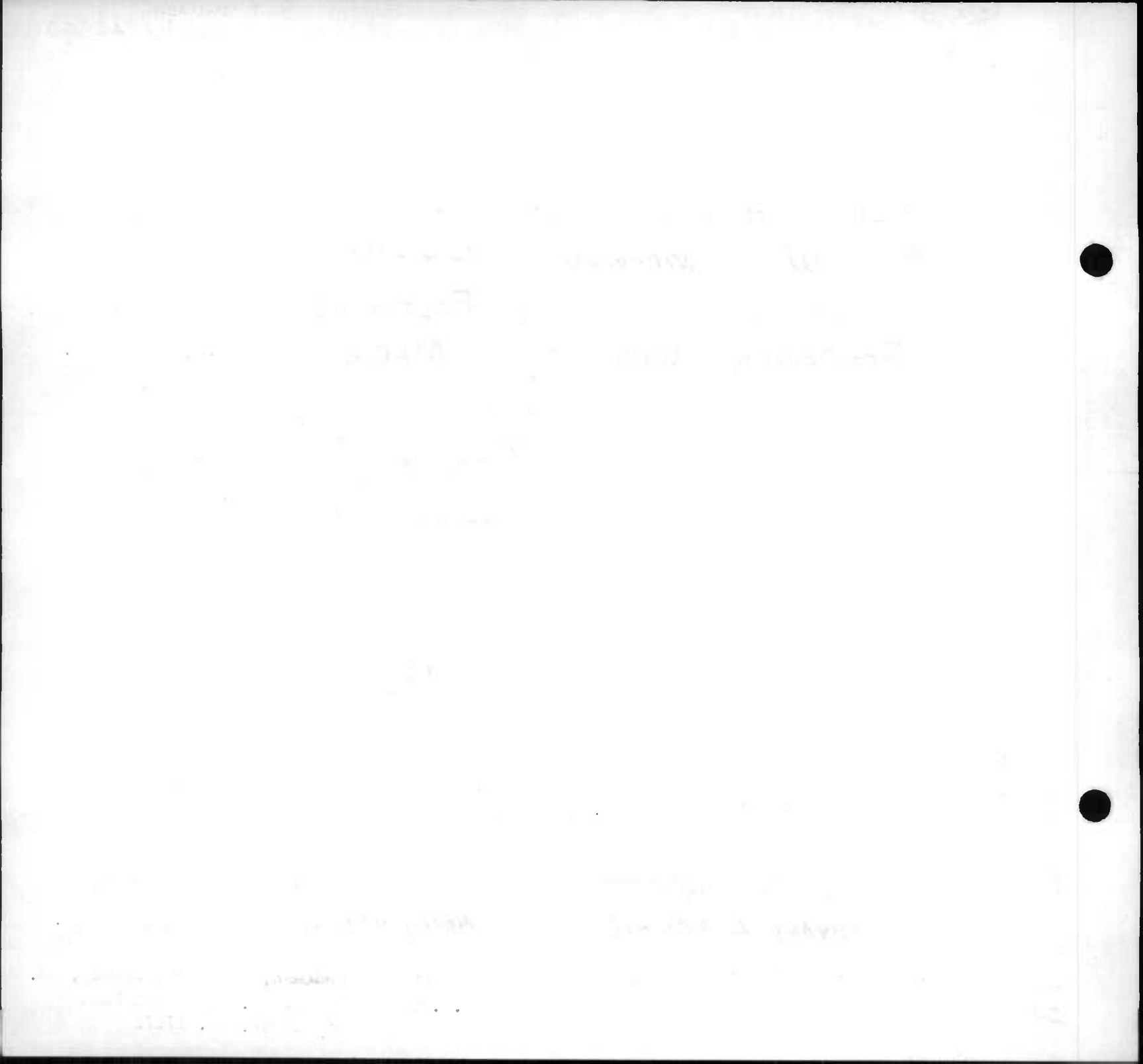
Robert E. Fairburne

25C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Road

ADDRESS

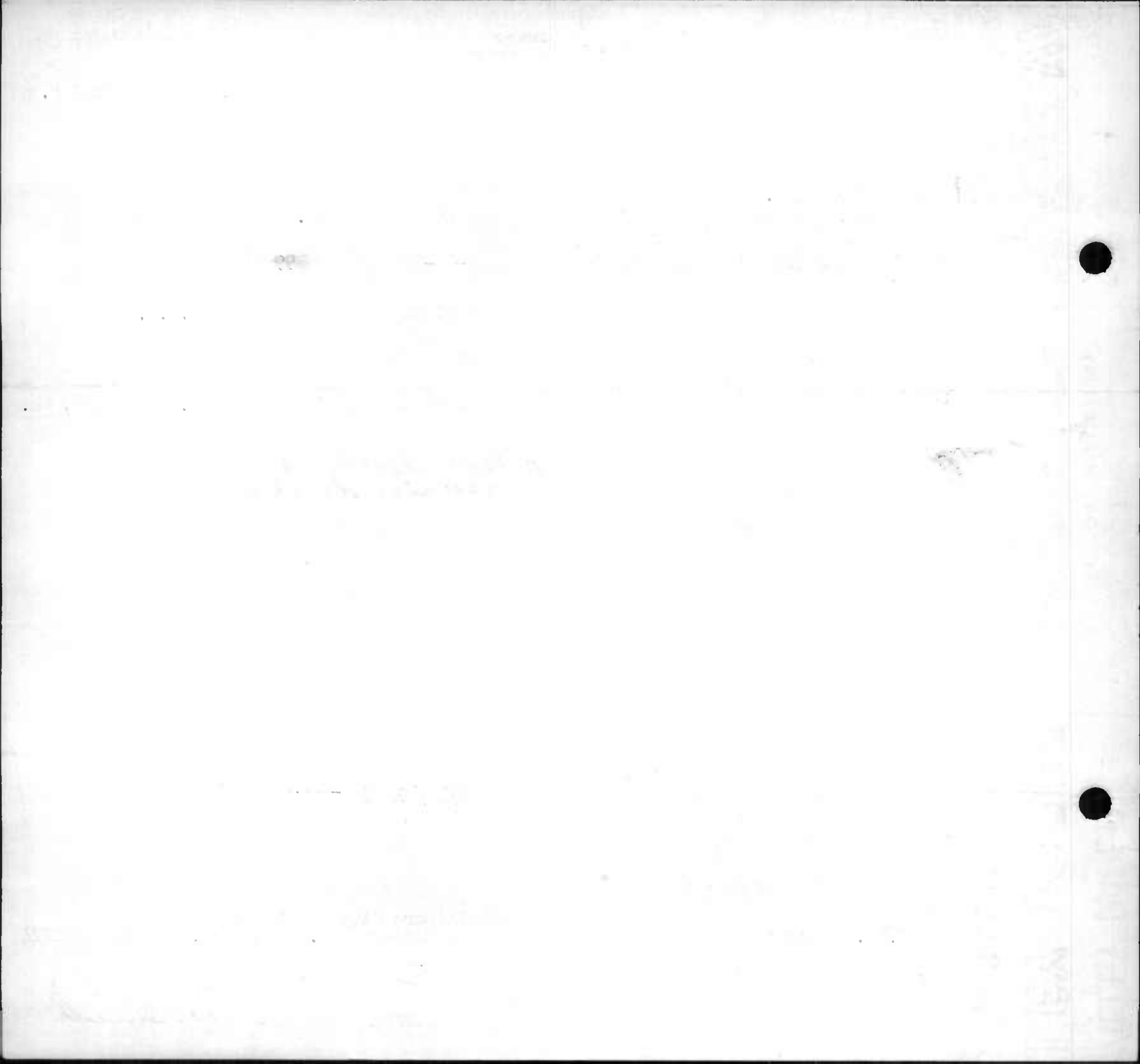
Baltimore, Md. 21212





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>H-350</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 11426</b>	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Rachel Hayden</b>			<b>November 15, 1967 9:45 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> 4940 Eastern Ave. Baltimore, Maryland # 21224			A. STATE <b>Maryland</b> B. COUNTY		
5. SEX <b>Female</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
6. RACE <b>Negro</b>			D. STREET ADDRESS (If rural, give location) <b>4940 Eastern Ave. # 21224</b>		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Never married</b>			8. DATE OF BIRTH <b>3-14-68</b>		
9. AGE (In years last birthday) <b>99</b>			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>??</b>			14. MOTHER'S MAIDEN NAME <b>??</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			17. INFORMANT <b>BCH: Records 4940 Eastern Ave. Baltimore, Md.</b>		
18. <b>422/1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Arterio-sclerotic cardio-vascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <b>No</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that <del>(1)</del> (this hospital) attended the deceased from <b>5/19/1886</b> to <b>11/15/67</b> and that <del>(1)</del> (we) last saw the deceased alive on <b>11/15</b> 19 <b>67</b> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(We)</del> (We) (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>H. M. Meagher</b>			23B. DATE SIGNED <b>11/15/67</b>		
23C. PHYSICIAN'S NAME (Type) <b>H. M. Meagher</b>			23D. ADDRESS <b>Baltimore City Hospitals</b> 4940 Eastern Ave. Baltimore, Maryland #21224		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-27-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Sacred Heart Cemetery, Baltimore, Md.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 28 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Walter J. Jankowski</b>		25D. ADDRESS <b>1015 Dundalk Ave.</b>			



I approve that this case was released by Dr. Spiringgate at 9:05 AM on 11/26/67

FUNERAL DIRECTOR: IMPORTANT - This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11427				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11427	
M.E. CASE NO.				CERIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FROCK, MARGARET ANN				2. DATE AND HOUR OF DEATH 1.05 AM 11/26/67 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hosp				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4703 HAMPNETT ST.			
5. SEX female	6. RACE white	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 12/15/1890	9. AGE (In years last birthday) 77	10. CITIZEN OF WHAT COUNTRY? U.S. Maryland		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. Maryland	
13. FATHER'S NAME William Gaines				14. MOTHER'S MAIDEN NAME Gane unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220 52 4780		17. INFORMANT son, ADDRESS 3018 Virginia Ave. Balt. M.D. #15			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E 904.71 General Sepsis complicating fracture of left (subcapital) femur				INTERVAL BETWEEN ONSET AND DEATH 11/3/67 11/26/67			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 11/2/1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Austin-moore prosthesis		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) X		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) nursing home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4703 HAMPNETT AVE, BALTIMORE CITY			
21D. TIME OF INJURY (APPROX.) OCT 31 1967 10AM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? FELL IN BATHROOM			
22. I certify that (I) (this hospital) attended the deceased from OCT 31 1967 to NOV 26 1967, that (I) (we) last saw the deceased alive on NOV 25TH 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dew Younglee Cho				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/26/1967	
23C. PHYSICIAN'S NAME (Type) DR. PTUS-Y-H-CHO				23D. ADDRESS M.D. THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-29-67		24C. NAME OF CEMETERY or CREMATORY Lorraine Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. NOV 29 1967		25B. NAME OF REGISTRAR R. E. Johnson		25C. FUNERAL DIRECTOR ADDRESS Wm. E. Johnson, 8521 Loch Raven Blvd. 21204			

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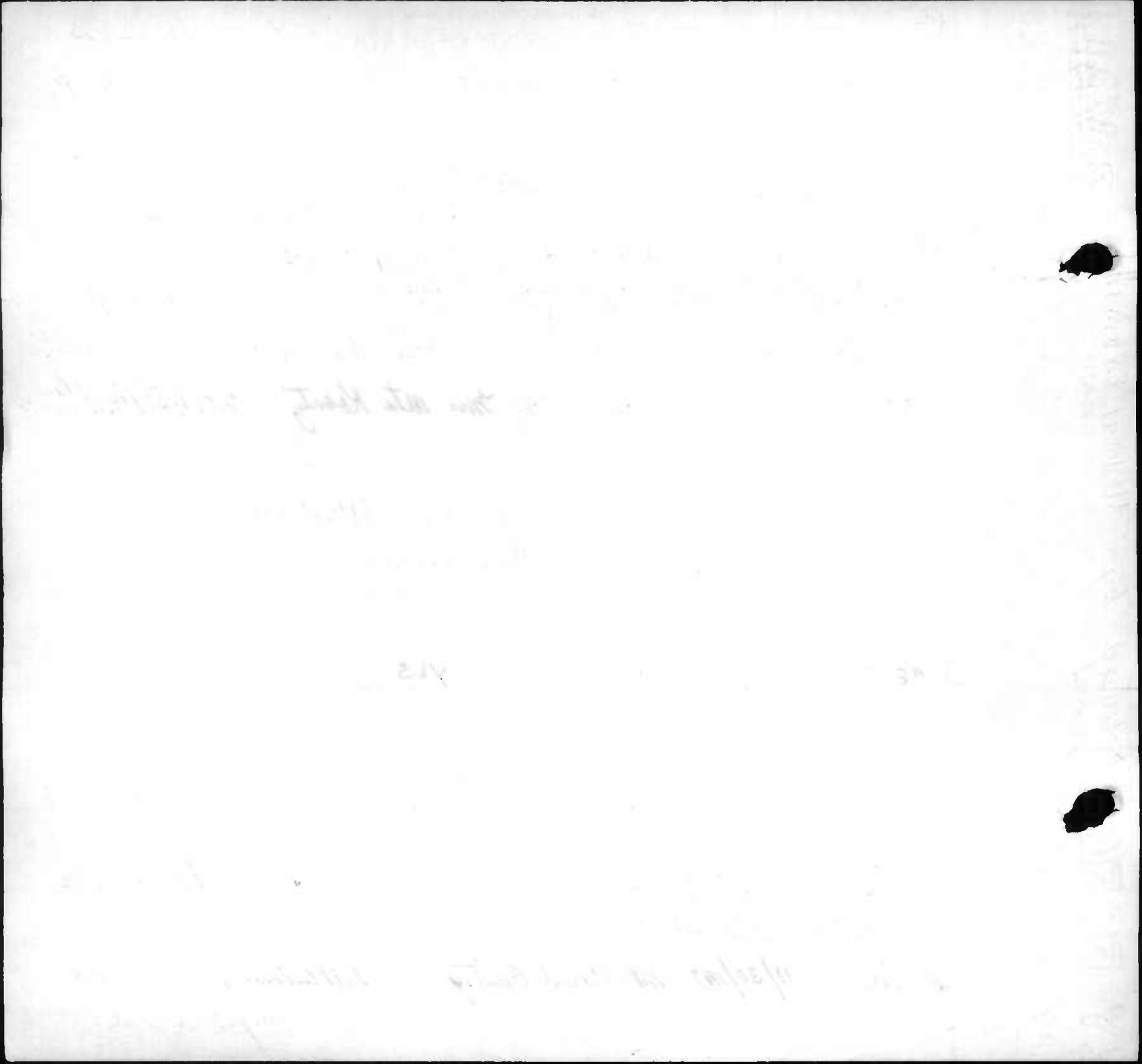
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 11/3/1917  
 11/4/1917

Released by Medical Examiner  
FUNERAL DIRECTOR: IMPORTANT  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

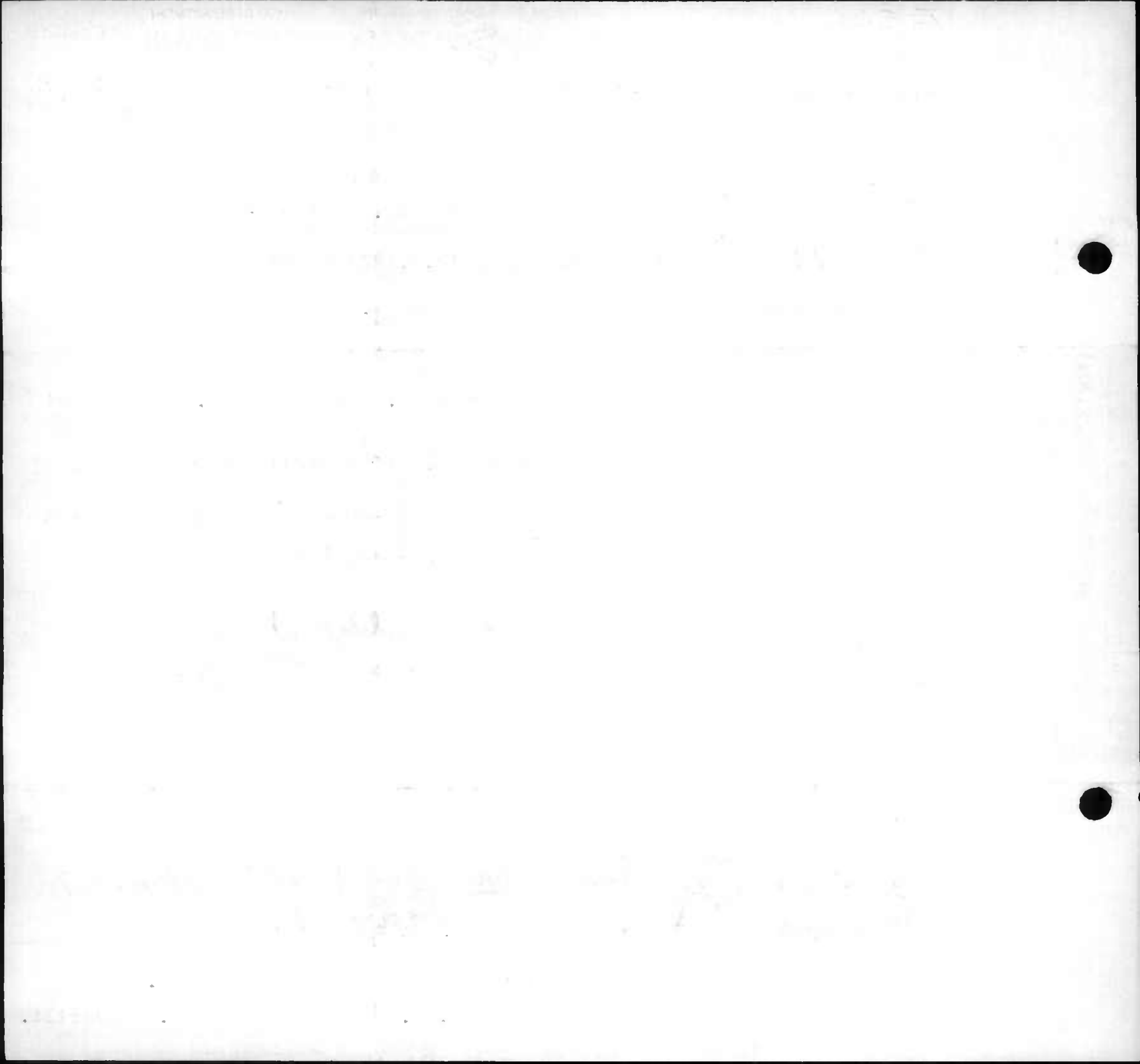
K-532		67 11428		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11428	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				KOONTZ, Harry Jerome		26 Nov. 1967 6:15 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
University of Maryland Hospital				Pennsylvania			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Hanover			
				D. STREET ADDRESS (If rural, give location)			
				201 N. Stephen Place			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Male		Cauc.		Married		21 Oct 1900	
9. AGE (In years, lost birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
67		Retired		Md.		U. S. A.	
10B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
owner - Canning Co.		Jerome Koontz		Gora Motock CORNELIA MORELOCK		No	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		INTERVAL BETWEEN ONSET AND DEATH	
166-12-7960		Mrs. Alta Koontz		2017 Stephen Place Hanover, Pa.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) Ruptured & Dissected DUE TO Tubercic Arteriosclerosis (B) DUE TO (C) Aneurysm			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
25 Nov 1967		above		YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from		26 Nov 1967		1967 to		24 Nov 1967	
that (I) (we) last saw the deceased alive on		26 Nov 1967		and that in (my) (our) opinion death occurred on the date		and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Santos, Ch. D.						26 Nov. 1967	
23C. PHYSICIAN'S NAME (Type)		M.D.		23D. ADDRESS			
Deffin S. Santos							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		11/30/1967		Mt Carmel Cemetery		Littletown, Pa.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 29 1967		Robert E. Fairbank		Tipton - Chine		Hampstead, Md.	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-500		67 11429		BALTIMORE CITY HEALTH DEPARTMENT		67 11429	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				WINIFRED R. TAWNEY		24 NOV 67 10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
37 Mercy Hospital				Maryland			
5. SEX				6. DATE OF BIRTH			
F				July 4, 1934			
7. RACE				9. AGE (In years last birthday)			
W				33			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
At Home				Penna.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
						Ernest R. Tawney 625 St. Paul Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		Bleeding Esophageal Varices		24 hrs.	
19. ANTECEDENT CAUSES		(B) DUE TO		Cirrhosis of Liver (alcoholic)		2-3 yrs.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO		Chronic Alcoholic		?	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Subacute TBC probably active			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from 11-14 1967 to 11-24 1967. that (2) (we) last saw the deceased alive on 11-24 1967 and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Salvatore R. Donohue						25 NOV 67	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS	
SALVATORE R. DONOHUE M.D.						MERCY HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9/28/67		New Cathedral		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 29 1967		Robert E. Johnson		H. W. Mears & Son		805 N. Calvert St.	





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67 11430 CERTIFICATE OF DEATH					Registered No. 67 11430					
BIRTH NO. <b>G-000</b>					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>Gay, Harry V.</b>					2. DATE AND HOUR OF DEATH <b>11/24/67 2:00 A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Union Memorial Hosp</b>					A. STATE <b>Md</b> B. COUNTY <b>Balt. City</b>					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 53-00</b>					
					D. STREET ADDRESS (If rural, give location) <b>8721 Edgington Road</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <b>09/21/1972</b>	9. AGE (In years last birthday) <b>72</b>	10. Under 1 Yr. Months: Days		11. Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter retired</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Carpenter Construction</b>		11. BIRTH PLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>James Gay</b>					14. MOTHER'S MARRIED NAME <b>Unknown</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>212 09 1488</b>		17. INFORMANT <b>Wife</b>		ADDRESS <b>Same</b>		
18. <b>420.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic heart disease &amp; congestive heart failure</b>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH <b>to K. date</b>					
<b>II</b>										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <b>2</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>11/24</b> to <b>11/24</b> and that (I) (we) last saw the deceased alive on <b>11/24</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>Dr. Barry J. Weckesser, MD</b>								23B. DATE SIGNED <b>11/24/67</b>		
23C. PHYSICIAN'S NAME (Type) <b>DR. BARRY J. WECKESSER MD.</b>					23D. ADDRESS <b>THE UNION MEMORIAL HOSP.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-27-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Mem. Park Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 29 1967</b>			25B. NAME OF REGISTRAR <b>Robert E. Farley</b>			25C. FUNERAL DIRECTOR <b>Wm. E. Johnson</b>			ADDRESS <b>8521 Loch Raven Blvd. 21204</b>	

James Gay  
retired  
W

Wife  
Maryland  
02/21/91 to  
8 251 Edgington road

Chesapeake bank branch  
5 corporate bank for line

back door

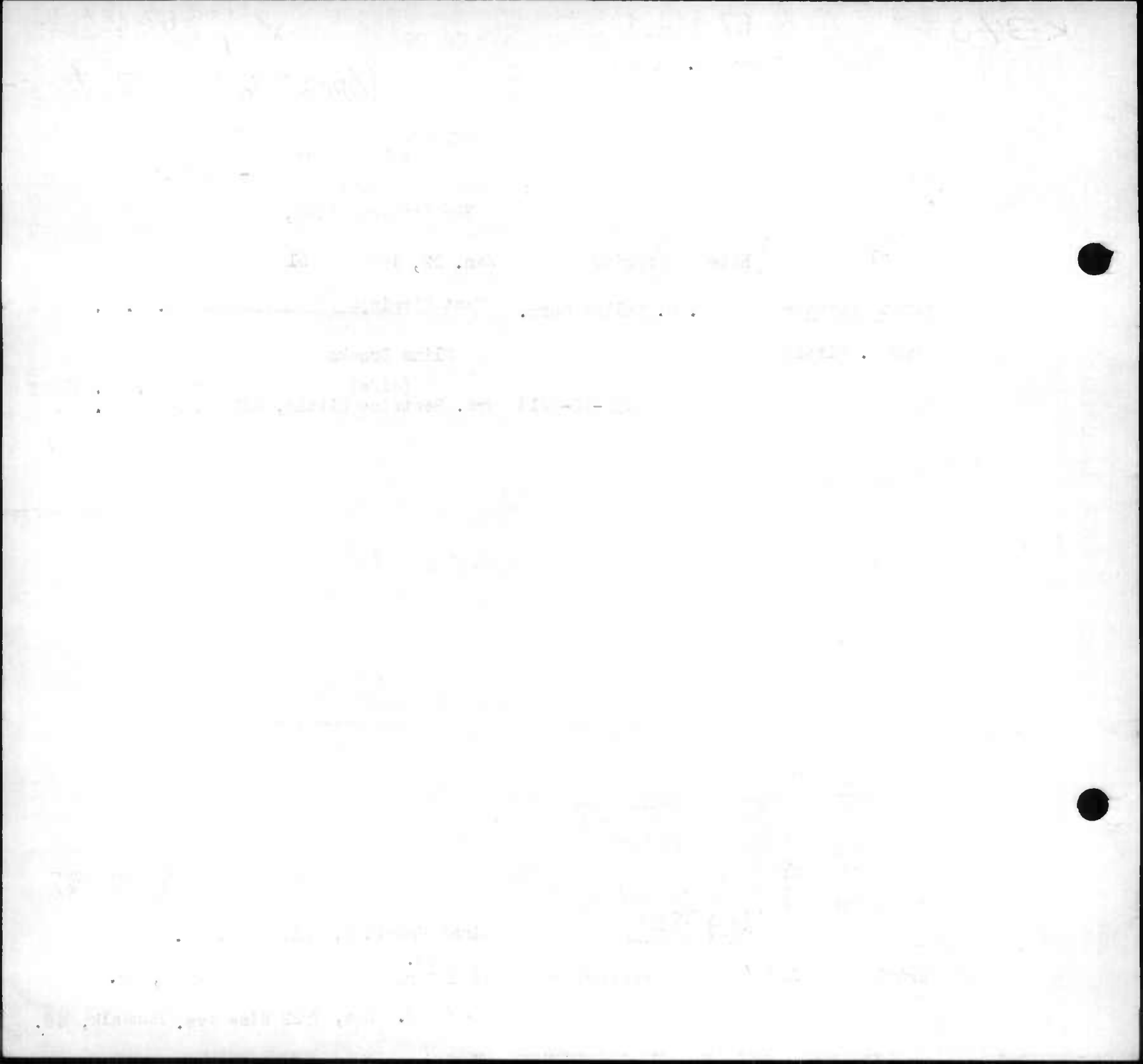
Officer  
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1/20/91

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11431		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11431	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		Herman O. Kittle		Nov 27, 1967 7:16P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
425 SINAI HOSPITAL		Maryland Baltimore Co			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Balt., Md. - Dundalk 53-00			
		D. STREET ADDRESS (If rural, give location)			
		225 Parkwood Road,			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Male	White	Married	Jan. 22, 1906	61	U. S. A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Garnet Operator		R. C. Heller Corp.		West Virginia	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Arch D. Kittle			Plina Brooks		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT (Wife) ADDRESS	
No		235-12-9218		Dundalk, Md. 21222	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Cardiac arrest Pericardial effusion 2° to adenocarcinoma - 6 months by hx Primary - unknown (? Lung, esophagus) Paroxysms		Sudden 7:16 PM	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/18/67 to 11/27/67, that (I) (we) last saw the deceased alive on 7:16 PM 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
A S Glushakov				Nov 27, 1967	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
KASSEL				Sinai Hospital, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12/1/67		Cem. Meadowridge Memorial Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 29 1967		Robert E. Farber		John J. Duda, 7922 Wise Ave. Dundalk, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

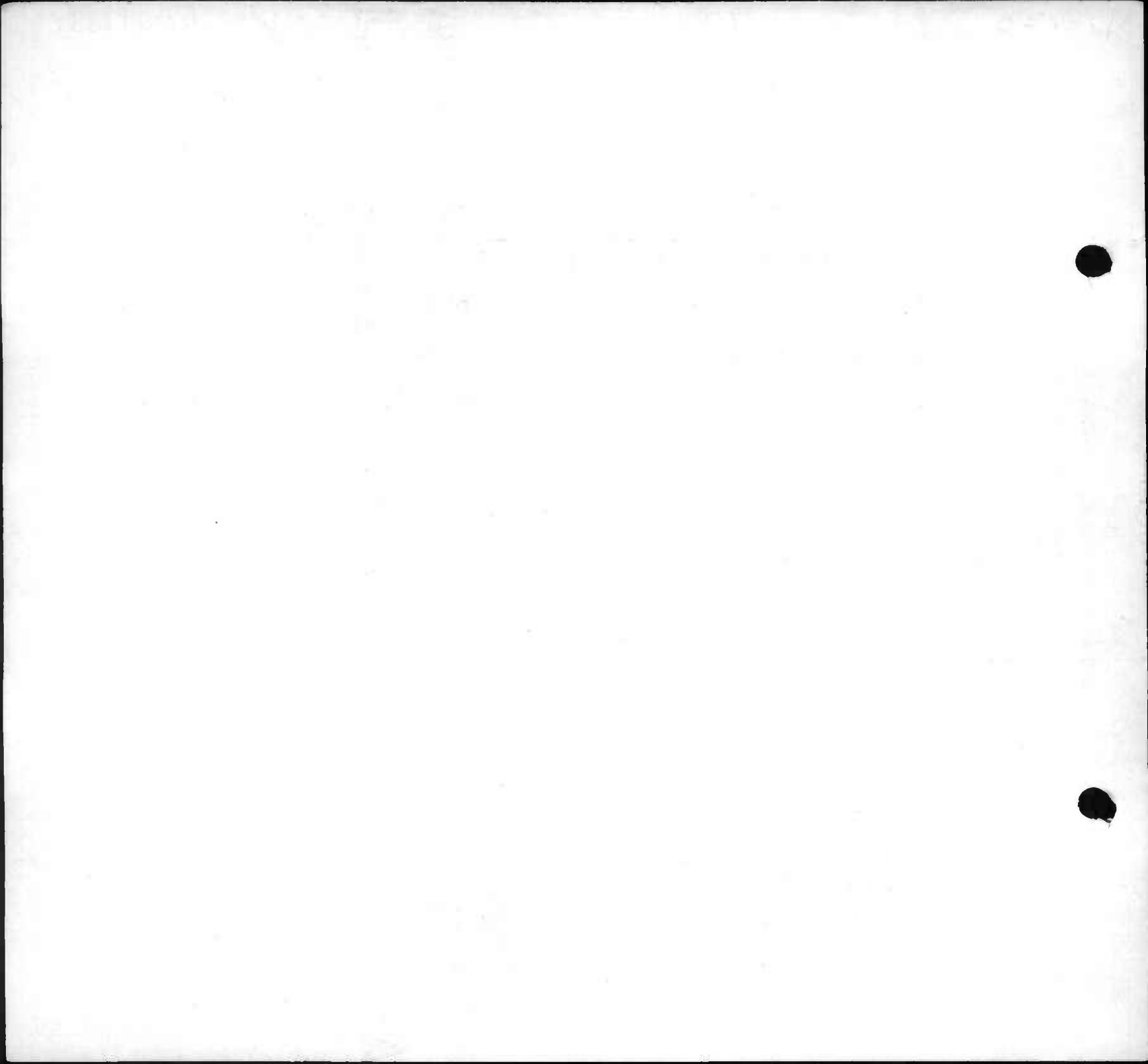
BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 67 11432		CERTIFICATE OF DEATH	
M.E. CASE NO.		Registered No. 67 11432	
1. NAME OF DECEASED (Type or Print) <b>LAWRENCE ROY ELLINGTON</b>		2. DATE AND HOUR OF DEATH <b>11-27-67 9:20 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Franklin Square Hospital</b> <b>FRANKLIN SQUARE HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>DUNDALK 53-00</b> D. STREET ADDRESS (If rural, give location) <b>2901 DUNMORE ROAD</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>8-15-03</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co.</b>	9. AGE (In years last birthday) <b>64</b>
11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES ELLINGTON</b>		14. MOTHER'S MAIDEN NAME <b>REGINA HUNT</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>237-07-1244</b>	
17. INFORMANT (Name) <b>Mrs. Bessie Ellington, 2901 Dunmore Rd.</b>		18. ADDRESS <b>Dundalk, Md.</b>	
19. CAUSE OF DEATH <b>Acute Myocardial Infarction</b>		20. INTERVAL BETWEEN ONSET AND DEATH	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
23. DATE OF OPERATION <b>0</b>		24. CONDITION FOR WHICH OPERATION WAS PERFORMED	
25. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
27. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		28. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		30. HOW DID INJURY OCCUR?	
31. I certify that (I) (this hospital) attended the deceased from <b>NOV. 17/67</b> 19 to <b>NOV. 27</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>NOV. 27</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		32. DATE SIGNED <b>11-27-67</b>	
33. SIGNATURE <b>Ruben V. Luna</b>		34. ADDRESS <b>FRANKLIN SQUARE HOSPITAL</b>	
35. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		36. DATE <b>11/30/67</b>	
37. NAME OF CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>		38. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>	
39. DATE REC'D BY HEALTH DEPT. <b>NOV 29 1967</b>		40. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>	
41. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		42. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 11433		67 11433		67 11433	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Robert I. Dorsey			11-27-1967 9:50 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
90 6116 Behanz Rd. Gould Con. Home			MD Baltimore 53-00		
5. SEX			6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)
M			White		WIDOWED
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH
ST. ENG.			Retired		OCT. 21, 1883
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)
James Dorsey			UNK		84
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
NO					
17. INFORMANT			ADDRESS		
Family			Same		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
Senility					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Nov. 14 1967 to Nov. 27 1967, that (I) (we) last saw the deceased alive on Nov. 26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
H. V. Harbold				Nov. 28, 1967	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
H. V. HARBOLD				4706 Harford Road Baltimore Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		11-30-67		Garden Hill Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 29 1967		Robert E. Feilinger		John H. Hahn	
				4200 Pennington Ave Baltimore 21226, Md.	





FUNERAL DIRECTOR: IMPORTANT

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W-4201		67 11434		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 11434	
1. NAME OF DECEASED (Type or Print) <b>WELLS, LILLIAN E.</b>				2. DATE AND HOUR OF DEATH <b>NOVEMBER 26, 1967 7:20 P.</b> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL CATON &amp; WILKENS AVES. BALTIMORE, MD. 21229</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>ANNE ARUNDEL G.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>SEVERN, 21144</b> D. STREET ADDRESS (If rural, give location) <b>CLARKS STATION RD.</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>9-14-98</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DANIEL VICKERS</b>				14. MOTHER'S MAIDEN NAME <b>LILLIAN HYATT</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Charles E. Wells (husb)</b> ADDRESS <b>AVES. 21229</b>			
				<b>ST. AGNES HOSP. RECORDS-WILKENS &amp; CATON</b>					
18. <b>570.31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>PERITONITIS &amp; DEHYDRATION</b> INTERVAL BETWEEN ONSET AND DEATH				(A) DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO <b>due to volubility causing</b>					
				(C) <b>Intestinal Obstruction</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>11-23-67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Volubility Intestinal Obst</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (natally medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 21</b> 19 <b>67</b> to <b>NOVEMBER 26</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 26</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>R. Suarez</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/27/67</b>			
23C. PHYSICIAN'S NAME (Type) <b>R. SUAREZ</b>				23D. ADDRESS M.D. <b>WILKENS &amp; CATON AVES. ST. AGNES HOSP. - BALTIMORE, MD. 21229</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>NOV. 29/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>GLEN HAVEN MEMORIAL PARK</b>		24D. LOCATION (City, town, or county) (State) <b>GLEN BURNIE, MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 29 1967</b>		25B. NAME OF REGISTRAR <i>R. E. Finkbeiner</i>		25C. FUNERAL DIRECTOR <i>R. Singleton</i>		ADDRESS <b>SINGLETON FUNERAL HOME GLEN BURNIE, MO.</b>			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BIRTH NO.</b> 67 11435</p> <p><b>CERTIFICATE OF DEATH</b></p> <p style="text-align: right;">Registered No. 67 11435</p>			
<p><b>M.E. CASE NO.</b></p> <p><b>1. NAME OF DECEASED</b> (Type or Print) <i>Gallagher, Emily E.</i></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <i>11-27-67 6:25 a.m.</i></p>	
<p><b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b></p> <p><b>CERTIFICATE AMENDED</b> 12-1-67</p> <p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give address or location) <i>Bon Secours Hosp.</i></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <i>Md.</i> B. COUNTY <i>Anne Arundel Co.</i></p> <p><b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township) <i>Glen Burnie 52-00</i></p> <p><b>D. STREET ADDRESS</b> (If rural, give location) <i>1419 Rowe Drive</i></p>	
<p><b>5. SEX</b> <i>F</i></p>	<p><b>6. RACE</b> <i>W.</i></p>	<p><b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</b> <i>Married</i></p>	<p><b>8. DATE OF BIRTH</b> <i>Mar 3-3-27</i></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Housewife</i></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <i>Own Home</i></p>	<p><b>11. BIRTHPLACE</b> (State or foreign country) <i>Canada</i></p>
<p><b>13. FATHER'S NAME</b> <i>Clayton, Robert</i></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <i>Dart (Helen)</i></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i></p>		<p><b>16. SOCIAL SECURITY NO.</b> <i>214 14 9852</i></p>	<p><b>17. INFORMANT</b> <i>Mr. Andrew Gallagher (Husband)</i></p> <p><b>ADDRESS</b> <i>Admission Sheet Same As #2</i></p>
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><i>260X1</i></p>		<p><b>CAUSE OF DEATH</b></p> <p>(A) <i>C.V.A.</i></p> <p><b>DUE TO</b></p> <p>(B) <i>Diabetic acidosis</i></p> <p><b>DUE TO</b></p> <p>(C)</p>	
<p><b>INTERVAL BETWEEN ONSET AND DEATH</b></p>		<p><b>II</b></p> <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b></p>	
<p><b>19A. DATE OF OPERATION</b> <i>0</i></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	
<p><b>20A. AUTOPSY?</b> (Yes or No) <i>NO</i></p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>		<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)</p>	
<p><b>21E. INJURY OCCURRED</b></p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from <i>11/24/67</i> to <i>11/27/67</i>, that (I) (we) last saw the deceased alive on <i>11/27/67 6:25 a.m.</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <i>Mohamadi</i></p>		<p><b>23B. DATE SIGNED</b> <i>11/27/67</i></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <i>MOHAMADI</i></p>		<p><b>23D. ADDRESS</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <i>Burial</i></p>		<p><b>24B. DATE</b> <i>Nov. 30/67</i></p>	
<p><b>24C. NAME OF CEMETERY or CREMATORY</b> <i>Meadowridge Mem. Park</i></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State) <i>Elkridge, RFD, Maryland</i></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b></p>		<p><b>25B. NAME OF REGISTRAR</b> <i>Robert E. Fairbank</i></p>	
<p><b>25C. FUNERAL DIRECTOR</b> <i>Singleton Funeral Home</i></p>		<p><b>ADDRESS</b> <i>Glen Burnie, Md.</i></p>	

Birth Certificate of Deceased from  
Ontario, Canada 12-1-67 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 11436		67 11436	
BIRTH NO.				67 11436		CERTIFICATE OF DEATH	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				DORSEY N. OWENS		11/27/67 6:30 PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. SEX	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
Maryland General Hospital				MD.		Anne Arundel Co 52-00	
6. CITY OR TOWN (If outside city limits, write RURAL and give township)				7. STREET ADDRESS (If rural, give location)		8. DATE OF BIRTH	
RURAL - LINTHICUM HEIGHTS				209 ARUNDEL Rd.		12/9/92	
9. SEX				10. RACE		11. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
M				W		MARRIED	
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				13. KIND OF BUSINESS OR INDUSTRY		14. BIRTHPLACE (State or foreign country)	
Self Employed				Business Forms		OREGON	
15. FATHER'S NAME				16. MOTHER'S MAIDEN NAME		17. CITIZEN OF WHAT COUNTRY?	
William OWENS				NETTIE WOLF		USA	
18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				19. SOCIAL SECURITY NO.		20. INFORMANT	
no				216 010 306		Mr. James Owens (son)	
21. ADDRESS				22. ADDRESS		23. ADDRESS	
Vienna, Va.				Vienna, Va.		Vienna, Va.	
24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				25. CAUSE OF DEATH		26. INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) PNEUMONIA		one day	
27. ANTECEDENT CAUSES				(B) CHRONIC obstructive Airway dis.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
29. DATE OF OPERATION				30. CONDITION FOR WHICH OPERATION WAS PERFORMED		31. AUTOPSY? (Yes or No)	
NO						NO	
32. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)				33. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		34. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (this hospital) attended the deceased from 10-11 1967 to 11-27 1967, that (I) last saw the deceased alive on 11-27 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23. SIGNATURE		24. DATE SIGNED	
Ralph D. Raymond				M.D.		11-27-67	
25. PHYSICIAN'S NAME (Type)				26. ADDRESS		27. DATE SIGNED	
Ralph D. REYMOND				M.D.		11-27-67	
28. BURIAL CREMATION, REMOVAL (Specify)				29. DATE		30. NAME OF CEMETERY OR CREMATORY	
Burial				Nov. 30/67		Loudon Park Cemetery	
31. DATE REC'D BY HEALTH DEPT.				32. NAME OF REGISTRAR		33. FUNERAL DIRECTOR	
NOV 29 1967				G. E. Jackson		R. Singleton	
34. ADDRESS				35. ADDRESS		36. ADDRESS	
Singleton Funeral Home				Glen Burnie, Md.		Glen Burnie, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11437		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11437	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>DE VINCENT, MICHAEL</b>			2. DATE AND HOUR OF DEATH <b>Nov. 27, 1967</b> <b>9<sup>25</sup> A</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>FRANKLIN SQUARE HOSPITAL</b> <b>36</b>			A. STATE <b>MARYLAND</b> B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		
			D. STREET ADDRESS (If rural, give location) <b>26 E HAMBURG ST.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <b>May 8 1892</b>	9. AGE (In years last birthday) <b>75</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tile Mason</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>ITALY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>EDWARD DE VINCENT</b>			
14. MOTHER'S MAIDEN NAME <b>ANGELINA DE ROCCO</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Dominic DeVincent 10 E. Hamburg St.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>420.1153.0</b> <b>Coronary Sclerosis</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>		
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>Nov. 24, 1967</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Coronary - circum</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Nov. 21</b> 19 <b>67</b> to <b>Nov. 27</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Nov. 27</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Thomas A. Alvero</b> M.D.				23B. DATE SIGNED <b>11/27/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Thomas A. Alvero</b> M.D.				23D. ADDRESS <b>FRANKLIN SQUARE HOSP.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12 1 67</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Cross</b>	
24D. LOCATION (City, town, or county) (State) <b>Brooklyn, A. A. Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <b>Mc Gully</b>		25C. FUNERAL DIRECTOR ADDRESS <b>130 E. Fort Ave</b>			

THE UNIVERSITY OF CHICAGO  
DIVISION OF THE PHYSICAL SCIENCES  
DEPARTMENT OF CHEMISTRY

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 11438</u>	
67 11438				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>DAVID, CURTIS</b>				2. DATE AND HOUR OF DEATH <b>November 28, 1967 1:40 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Johns Hopkins Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>---</b>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
				D. STREET ADDRESS (If rural, give location) <b>2119 Sinclair Lane</b>	
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>2/22/18</b>	9. AGE (In years last birthday) <b>49</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shipyard</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>General But</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <b>James Curtis</b>		
14. MOTHER'S MAIDEN NAME <i>unknown</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		
16. SOCIAL SECURITY NO.			17. INFORMANT <i>Walter Davis</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic bronchitis and emphysema</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/21/1967</u> to <u>11/28/1967</u> and that (I) (we) lost saw the deceased alive on <u>11/28/1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>David J. Shaw</i>				23B. DATE SIGNED <b>11/28/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>DAVID J. SHAW M.D.</b>				23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-1-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Not Under Contract</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 29 1967</b>			
25B. NAME OF REGISTRAR <i>W. E. J. J. J.</i>		25C. FUNERAL DIRECTOR <i>Gray &amp; Wilson 1000 Broadway Ave</i>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

SARAH

MC COY

2. DATE AND HOUR PRONOUNCED DEAD

November 23, 1967 6:50 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

701 Woodington Road

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

May 20, 1888

9. AGE (in years  
last birthday)

88

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Alabama

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jim Mc Coy

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mac Mc Coy

ADDRESS

Sinner

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Fracture of Humerus

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Balto. Beltway - Route 2 - County

Anne Arundel

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

11/4/67

6:50 A.M.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Passenger in an auto  
that went over an embankment

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

11/24/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11-28-67

23C. NAME OF CEMETERY or CREMATORY

Fellowship Cem.

23D. LOCATION

(City, town, or county)

(State)

Alabama

24A. DATE REC'D BY HEALTH DEPT.

NOV 29 1967

24B. NAME OF REGISTRAR

Robert E. Spitz

24C. FUNERAL DIRECTOR

E. O. Wilson 1004 S. Highway 48.  
Late Funeral Home - Thomasville, ALA.

ADDRESS

UNITED STATES

DEPARTMENT OF JUSTICE

INVESTIGATION

REPORT

NO. 1

WAS THE CASE

KNOW

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-542		67 11440		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11440	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Daniels, Charlie				11.24.67 11 30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 33				Maryland Baltimore			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 3-01			
The Johns Hopkins Hospital				D. STREET ADDRESS (If rural, give location) 29 S. Dallas St.			
5. SEX Male	6. RACE Negroid	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 11-20-22	9. AGE (In years last birthday) 45	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cheston South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Berry D aniels				14. MOTHER'S MAIDEN NAME Maggie Holsey			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Salhe Bright		ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cardiac arrest (B) Intracerebral bleeding - vs Pul. embolus (C) Malignant Hypertension				INTERVAL BETWEEN ONSET AND DEATH 1 hr. 1 1/2 hr.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11-22 1967 to 11-24 1967, that (I) (we) last saw the deceased alive on 11-24 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Christopher B. Merritt M.D.				23B. DATE SIGNED 11.24.67			
23C. PHYSICIAN'S NAME (Type) Christopher B. Merritt M.O.				23D. ADDRESS Johns Hopkins Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11-28-67		24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cmt		24D. LOCATION (City, town, or county) (State) Brooklyn Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 29 1967		25B. NAME OF REGISTRAR Charles E. Jackson		25C. FUNERAL DIRECTOR Elroy Wilkerson		ADDRESS 1000 Maryland Ave	

[illegible]

on 22K

MC-11 Q3

PL 55-11



8

Christophers & Marent	8	11.24.11
Christophers & Marent	8	11.24.11

67 11441

BALTIMORE CITY HEALTH DEPARTMENT

67 11441

BIRTH NO.

M.E. CASE NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM LESTER PIGFORD

2. DATE AND HOUR PRONOUNCED DEAD

November 25, 1967 11:22 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1406 Ashland Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1406 Ashland Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Nov 11

9. AGE (In years  
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Labor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF  
WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

Stephen Pigford

14. MOTHER'S MAIDEN NAME

Ann Lee Seggett

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give year or date of service)

YES

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Laennec's cirrhosis  
DUE TOANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 26, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11-30-67

23C. NAME OF CEMETERY or CREMATORY

Baltimore Natl Cemetery

23D. LOCATION

(City, town, or county)

Baltimore

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 28 1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Sheryl Wilson 1000 Brantley Ave

ADDRESS

NO. 1234  
JAN 1950

WILLIAM H. HARRIS

1000 10th St.

NEW YORK, N.Y.

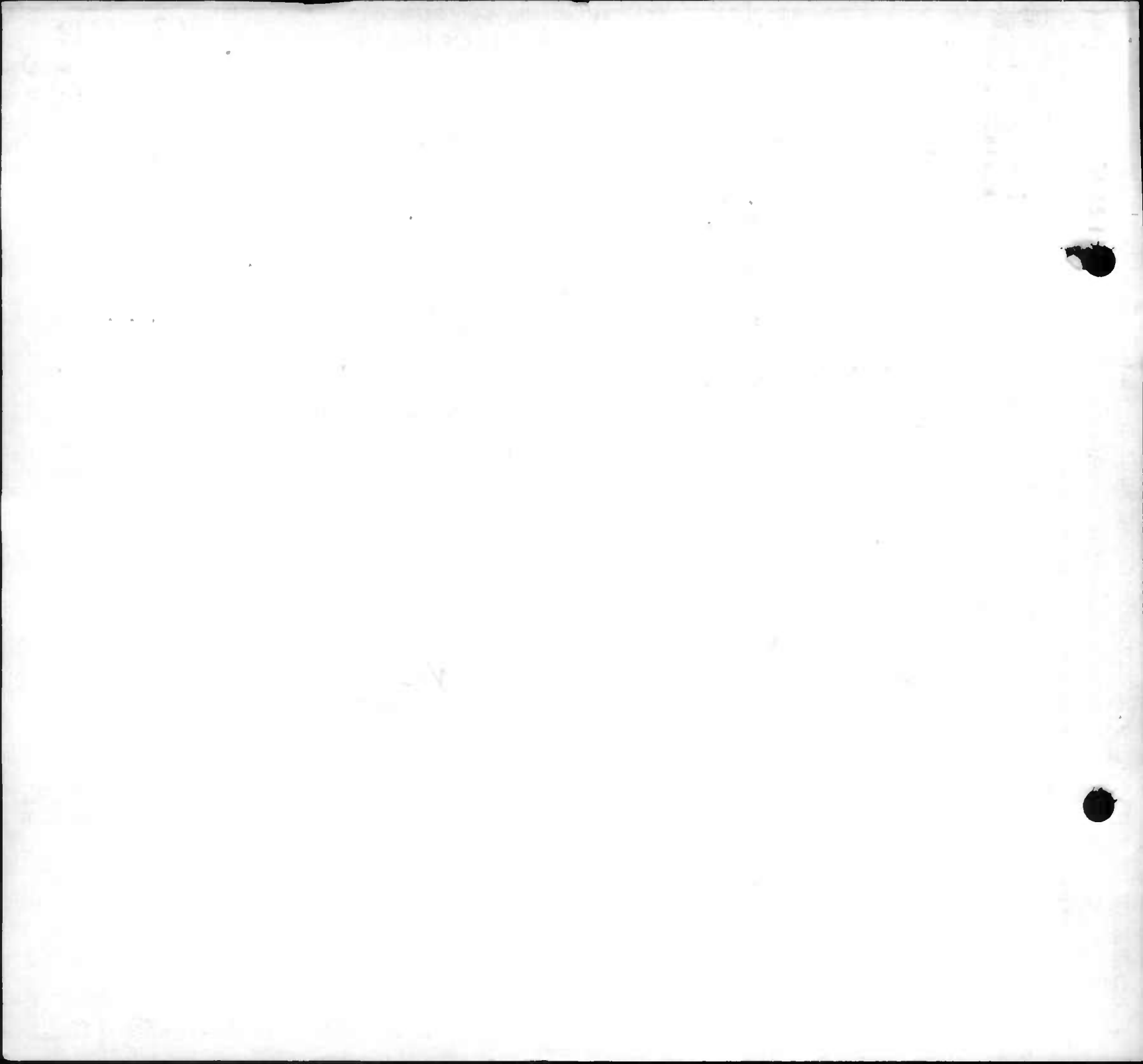
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-152		67 11442		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11442	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
JOHN ROBINSON				11/25/67 2:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
33 The Johns Hopkins Hospital 601 N. Broadway Baltimore, Maryland				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				810 N. Dallas Street			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Male		Negro		Never married		9/06/26	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
41 yrs.		Laborer		Virginia		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Green, Leroy				Travers, Irene			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES						John Robinson Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
331X I				INTRACEREBRAL		12 hours	
ANTECEDENT CAUSES				CERTIFICATION APPROVED BY			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CHIEF OF ASST. MEDICAL EXAMINER			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2-11-25-67		INTRACRANIAL HEMORRHAGE		YES		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 11/25/67 to 11/25/67 that (I) (we) last saw the deceased alive on 11/25/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
John R. Black M.D.				11/27/67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
HENRY R. BLACK M.D.				Johns Hopkins Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		11-30-67		Baltimore Mt. Cont		Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
NOV 23 1967		Robert E. Taylor		Joseph Wilson		1000 Brantley Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11443		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11443	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Margaret B. Clary</b>			2. DATE AND HOUR OF DEATH <b>November 26, 1967</b> <b>8<sup>00</sup> A</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>90 Wesley Home</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2211 W. Rogers Ave.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>2/11/1883</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>John D. Clary</b>			14. MOTHER'S MAIDEN NAME <b>Ida M. Storms</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>218-52-1303</b>	17. INFORMANT ADDRESS <b>The Wesley Home, Inc. same address</b>			
18. <b>170X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>RECURRENT AND METASTATIC</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Carcinoma breast, bilateral</b>			CAUSE OF DEATH (A) <b>RECURRENT AND METASTATIC</b> DUE TO (B) <b>CARCINOMA BREAST, BILATERAL</b> DUE TO (C)		
INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>23 Jan 67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma breast bilateral</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not White At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6 January 1967</b> to <b>26 November 1967</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>21 November 1967</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(we)</b> (did) <b>(did not)</b> view the body after death.					
23A. SIGNATURE <b>John W Barnaby</b>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <b>JOHN W BARNABY</b>			23D. ADDRESS M.D. <b>1531 E North Ave</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/28/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Johns Evangelical Church Cemet. Westminster, Md.</b>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 28 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Salzman</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. F. Tiekman &amp; Sons Baltimore, Md.</b>			

Mount and set to  
Cassius County, N.Y.

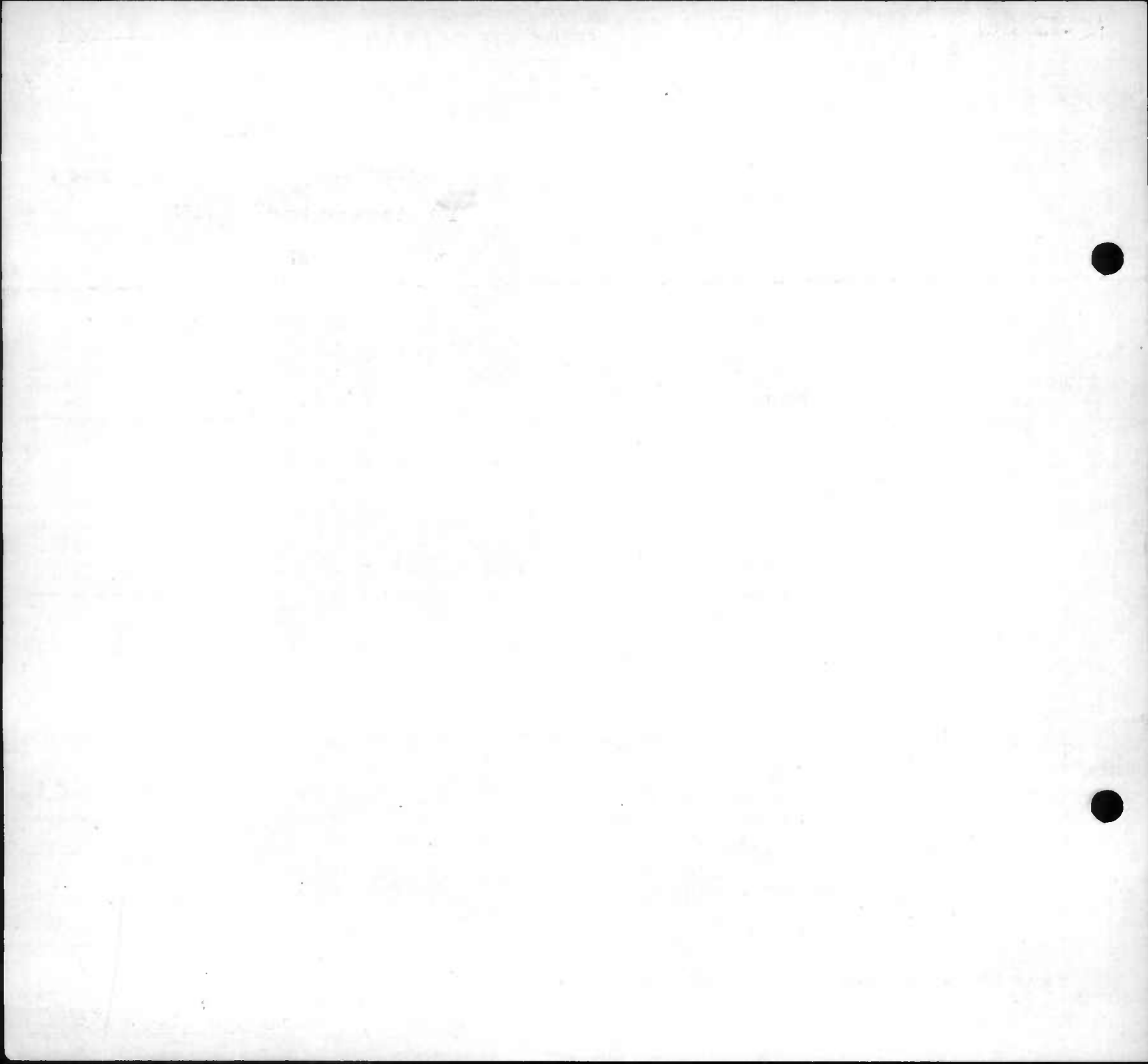
Wm. H. Brewster

John W. Brewster

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
67 11444						CERTIFICATE OF DEATH		Registered No. 67 11444			
BIRTH NO.						1. NAME OF DECEASED (Type or Print) <b>JULIUS J. KOZMA</b>					
2. DATE AND HOUR OF DEATH <b>11-23-67 5:45 AM</b>						3. PLACE OF DEATH IN BALTIMORE, MARYLAND					
FULL NAME OF HOSPITAL OR INSTITUTION <b>36 FRANKLIN SQUARE HOSPITAL</b>						(If not in hospital or institution, give street address or location)					
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)						A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore Co</b>					
C. CITY OR TOWN (If outside city limits, write RURAL and give township)						<b>Catonsville 53-00</b>					
D. STREET ADDRESS						<b>103 Birchwood Road 21228</b>					
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED, NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <b>10/16/87</b>		9. AGE (In years last birthday) <b>87</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>				11. BIRTHPLACE (State or foreign country) <b>HUNGARY</b>			
12. CITIZEN OF WHAT COUNTRY? <b>HUNGARY</b>				13. FATHER'S NAME <b>JOHN KOZMA</b>				14. MOTHER'S MAIDEN NAME <b>MARY CSAKANY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No None</b>				16. SOCIAL SECURITY NO. <b>213-34-648</b>				17. INFORMANT ADDRESS <b>FRANKLIN SQUARE HOSPITAL</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>4221</b> <b>PULMONARY EMBOLISM</b> <b>CHF 20 TO A.S.C.V.D.</b> <b>PNEUMONIA (?)</b>						CAUSE OF DEATH					
						INTERVAL BETWEEN ONSET AND DEATH					
						ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				22. I certify that (I) (this hospital) attended the deceased from <b>NOV. 11</b> 19 <b>67</b> to <b>NOV. 23</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>NOV. 23</b> 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE <b>Ruben V. Luna</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			
23B. DATE SIGNED <b>11-23-67</b>				23C. PHYSICIAN'S NAME (Type) <b>RUBEN V. LUNA</b> M.D.				23D. ADDRESS <b>FRANKLIN SQUARE HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>11/27/67</b>				24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine PK.</b>			
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>				25A. DATE REC'D BY HEALTH DEPT. <b>NOV 29 1967</b>				25B. NAME OF REGISTRAR <b>Robert E. Tarleton</b>			
25C. FUNERAL DIRECTOR <b>Wm. J. Tichner Son Balto Md</b>				25D. ADDRESS							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11445

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

67 11445

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Julia Harris.

2. DATE AND HOUR OF DEATH

11/25/67

8:00 AM

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(If not in hospital or institution, give street  
address or location)

Sinai Hospital of Baltimore  
42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Baltimore Md

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

Baltimore

15-10

D. STREET ADDRESS

(If rural, give location)

Haven Nursing Home, Penhurst.

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED  
(WIDOWED, DIVORCED (specify))

WIDOWED

8. DATE OF BIRTH

11/31/93

9. AGE (in years  
last birthday)

74

If Under 1 Yr.

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

Washington, DC

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

EUGENE G. LINCOLN

14. MOTHER'S MAIDEN NAME

MARY PHELPS

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

NONE

16. SOCIAL  
SECURITY NO.

NONE

17. INFORMANT

WILLIAM J. HARRIS JR ANNAPOLIS MD

ADDRESS

18.

561.1

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Cardiac Arrest -

(B) DUE TO

Atherosclerotic cardiovascular  
disease

(C)

Strangulated  
hernia

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Strangulated left femoral hernia  
e bowel resection  
enlarged umbilical hernia

19A. DATE OF OPERATION

11/20/67 - 11/21/67

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

Strangulated left femoral hernia  
e bowel resection  
enlarged umbilical hernia

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS

UNDERLYING

OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about

home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY

(Month) (Day) (Year) (Hour)

(APPROX.)

21E. INJURY OCCURRED

While At  
Work

Not While  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

11/20

1967 to

11/25

1967

that (I) (we) last saw the deceased alive on

11/25

1967

and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. M. Juanteguy

M.D.

Attending  
Phys.

Med.  
Director

Staff  
Phys.

23B. DATE SIGNED

11/25/67

23C. PHYSICIAN'S  
NAME (Type)

J. M. Juanteguy

M.D.

23D. ADDRESS

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION

(City, town, or county)

(State)

BURIAL 11/29/67

ARLINGTON NATL.

FORT MYER, VA.

25A. DATE RECEIVED AT HEALTH DEPT.

NOV 29 1967

25B. NAME OF REGISTRAR

Robert E. Taylor, Jr.

25C. FUNERAL DIRECTOR

W.W. CHAMBERS CO. 517 12th St. S.E. WASHINGTON, DC

10/20/71

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10/20/71

10/20/71



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made. RELEASED AS NOT A MEDICAL EXAMINER'S CASE BY DR. SPRINGER OF THE M.E. OFFICE.

S-260		67 11446		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11446	
BIRTH NO.				DATE AND HOUR OF DEATH			
M.E. CASE NO.				11/26/67 9:20 P.M.			
1. NAME OF DECEASED (Type or Print) John W. Souser				2. DATE AND HOUR OF DEATH			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital 33				A. STATE B. COUNTY Pennsylvania			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Mount Wolf V-35			
				D. STREET ADDRESS (If rural, give location) 411 - Maple St.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7/21/11	9. AGE in years lost birthday 56	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Production Control		10B. KIND OF BUSINESS OR INDUSTRY Container		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William SOUSER				14. MOTHER'S MAIDEN NAME Mary Williamson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 162 07 8920		17. INFORMANT ADDRESS Anna Mae Souser 411 Maple St. Mt. Wolf Pa.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH DUE TO (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) AORTO-DUODENAL FISTULA NOV. 1967.				INTERVAL BETWEEN ONSET AND DEATH NOV. 1967.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. AORTIC ANEURYSM. JAN 1965				DUE TO (B) AORTIC ANEURYSM. JAN 1965			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ARTERIOSCLEROTIC CARDIOVASCULAR - UNDERLYING DISEASE. MINIBABLE.				DUE TO (C) ARTERIOSCLEROTIC CARDIOVASCULAR - UNDERLYING DISEASE. MINIBABLE.			
19A. DATE OF OPERATION 11/24/67				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED AORTIC DUCT. FISTULA		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) None				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? None	
22. I certify that (I) (this hospital) attended the deceased from NOV. 24 19 67 to NOV 26 19 67, that (I) (we) lost saw the deceased alive on NOV 26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Stephen H. Bennett				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/26/67	
23C. PHYSICIAN'S NAME (Type) STEPHEN H. BENNETT				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/30/67		24C. NAME of CEMETERY or CREMATORY Prospect Hill Cem.		24D. LOCATION (City, town, or county) (State) York Co., Penna.	
25A. DATE REC'D BY HEALTH DEPT. NOV 29 1967		25B. NAME OF REGISTRAR A. E. F. F.		25C. FUNERAL DIRECTOR Wm. E. Johnson 8521 Loch Raven Blvd.		ADDRESS	

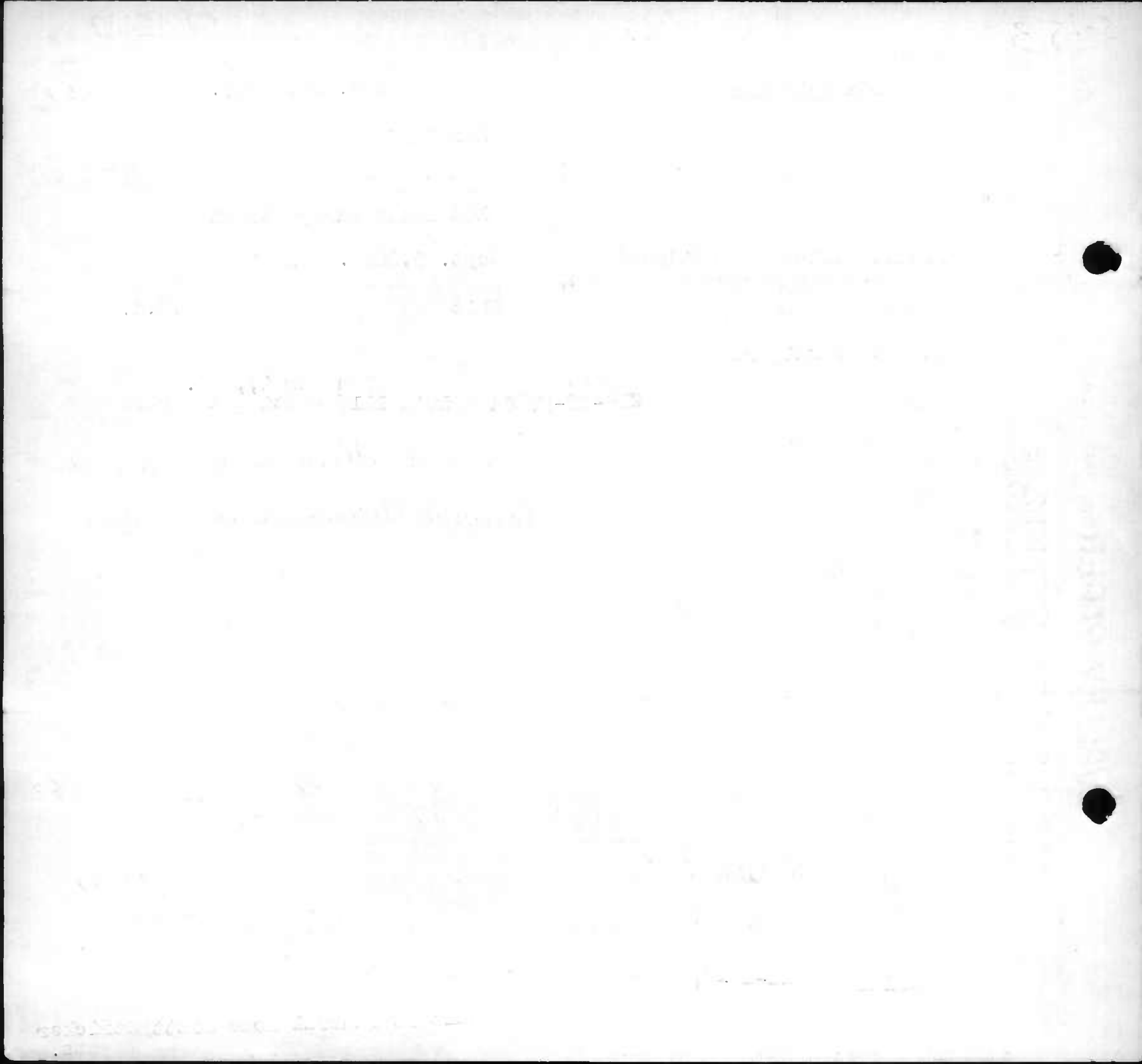
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In. 1/2

STEPHEN H. BARNETT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 11447</u>	
BIRTH NO. <u>67 11447</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <u>Nov. 25, 1967.</u> <u>2:05 P.M.</u>			
1. NAME OF DECEASED (Type or Print) <u>Ida Spindler</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Franklin Square Hospital</u> <u>36</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>104 South Carey Street</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 3, 1886.</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>August Schwaigert</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-09-9780A</u>		17. INFORMANT <u>Glen Burnie, Md.</u> <u>Sylvia 1116 Nottingham Drive</u>	
18. <u>332 XI</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Cerebral Thrombosis</u> DUE TO (B) <u>Cerebral Arteriosclerosis</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>2 yrs.</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>II</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>11/13</u> 19 <u>67</u> to <u>11/25</u> 19 <u>67</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>11/21</u> 19 <u>67</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <u>John P. Urlock Jr.</u>				23B. DATE SIGNED <u>11/27/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN P. URLOCK JR.</u>				23D. ADDRESS <u>1227 Washington Blvd</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>11-29-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Western Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>NOV 29 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Walters Funeral Home Pratt &amp; Stricker</u>			
25D. ADDRESS <u>Sts.</u>					



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 67 11448		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11448	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>HENRY E. LINDSAY</u>			<u>Nov 27 1967</u> <u>8:40 P. M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Edgewood Nursing Home</u> <u>6000 Bellona Ave., Balto., Md.</u>			A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u>		
5. SEX <u>Male</u>			6. DATE OF BIRTH <u>9/23/79</u>		
7. RACE <u>Negro</u>			9. AGE (In years last birthday) <u>88</u>		
8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>			10. AGE (In years last birthday) <u>88</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Link Lindsay</u>			14. MOTHER'S MAIDEN NAME <u>Emaline</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>216-10-4919</u>		
17. INFORMANT <u>Myrtle Lindsey</u>			ADDRESS <u>2331 Edmondson Avenue</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>420.1 L177X</u>			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
(A) <u>Myocardial infarction?</u> <u>seconds</u>					
(B) <u>Arteriosclerotic cardiovascular disease</u> <u>10+ yrs</u>					
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<u>Carcinoma of prostate - metastases</u> <u>1954 to 1967</u>		
19A. DATE OF OPERATION <u>0 1959</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Prostatectomy</u>		
20A. AUTOPSY? (Yes or No) <u>No</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 16 1967</u> to <u>Nov 27 1967</u> and that (I) (we) last saw the deceased alive on <u>Nov 27 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Frederick J. Vollmer</u>			23B. DATE SIGNED <u>Nov 27 1967</u>		
23C. PHYSICIAN'S NAME (Type) <u>FREDERICK J. VOLLMER</u>			23D. ADDRESS <u>6100 YORK RD</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>			24B. DATE <u>NOV 29 1967</u>		
24C. NAME OF CEMETERY OR CREMATORY <u>Arboretum Mem. Pk.</u>			24D. LOCATION (City, town, or county) (State) <u>Arboretum, Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 29 1967</u>			25B. NAME OF REGISTRAR <u>Geo. T. Kilson</u>		
25C. FUNERAL DIRECTOR <u>1348 N. Gallatin St.</u>			ADDRESS		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 11449					67 11449				
BIRTH NO.					Registered No.				
<div style="display: flex; justify-content: space-between;"> <div> <b>M.E. CASE NO.</b>            1. NAME OF DECEASED            (Type or Print) <b>DAVIS, BRADY</b> </div> <div> <b>2. DATE AND HOUR OF DEATH</b>  <b>11-28 '67 1:15 A.M.</b> </div> </div>									
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  <div style="display: flex; justify-content: space-between;"> <div> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>            (If not in hospital or institution, give street address or location)  <b>48 Maryland General Hosp</b> </div> <div> <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)            A. STATE <b>Maryland</b>            B. COUNTY <b>Baltimore</b>            C. CITY OR TOWN <b>Baltimore</b>            D. STREET ADDRESS <b>1904 Park Ave</b> </div> </div>									
<b>5. SEX</b> <b>Male</b>		<b>6. RACE</b> <b>Colored</b>		<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</b> <b>Married</b>		<b>8. DATE OF BIRTH</b> <b>9-14 '23</b>		<b>9. AGE</b> (In years lost birthday) <b>44</b>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10B. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>South Carolina</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>American</b>									
<b>13. FATHER'S NAME</b> <b>Brady Davis</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Anna Buckett</b>				
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give year or dates of service) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>218-14-1286</b>		<b>17. INFORMANT</b> <b>Ruby Davis</b>			
				<b>ADDRESS</b> <b>1904 Park Avenue</b>					
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>420.1 I</b> <b>Acute pulmonary edema</b> <b>INTERVAL BETWEEN ONSET AND DEATH</b>									
<b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Myocardial Infarction</b> <b>Atherosclerotic and hypertensive heart disease</b>									
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
<b>19A. DATE OF OPERATION</b> <b>2</b>			<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>			<b>20A. AUTOPSY?</b> (Yes or No) <b>Yes</b>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)			<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)			<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)			<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (this hospital) attended the deceased from 11-27 1967 to 11-28 1967, that (I) (we) last saw the deceased alive on 11-28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>									
<b>23A. SIGNATURE</b> <b>F. Bjornsson</b>						<b>23B. DATE SIGNED</b> <b>11-28 '67</b>			
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>F. BJORNSSON</b>						<b>23D. ADDRESS</b> <b>Maryland General Hospital</b>			
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>12/2/67</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Arbutus Mem. Ph.</b>		<b>24D. LOCATION</b> (City, town, or county) (State) <b>Arbutus, Md.</b>			
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>NOV 29 1967</b>		<b>25B. NAME OF REGISTRAR</b> <b>Charles E. Feltz</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Geo. D. Nelson Funeral Home 1348 Calhoun St</b>					

Mr. [illegible]  
[illegible]  
[illegible]  
[illegible]  
[illegible]

[illegible]  
[illegible]  
[illegible]  
[illegible]  
[illegible]



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **MARY KRACKE** 2. DATE AND HOUR PRONOUNCED DEAD **November 27, 1967 4:45 P. M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD **337 S. Smallwood St. (DOA)** 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) **Maryland**

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **337 S. Smallwood St. (DOA)** 5. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

6. STREET ADDRESS (If rural, give location) **337 S. Smallwood St.**

5. SEX **Female** 6. RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **WIDOWED** 8. DATE OF BIRTH **July 20, 1879** 9. AGE (In years last birthday) **88**

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife** 10B. KIND OF BUSINESS OR INDUSTRY **Domestic** 11. BIRTHPLACE (State or foreign country) **MARYLAND** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **August Such** 14. MOTHER'S MAIDEN NAME **LAAGE**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **NO** 16. SOCIAL SECURITY NO. **213-20-4969** 17. INFORMANT **HULTON KRACKE** ADDRESS **906 WILMINGTON AVE**

18. **422.1** CAUSE OF DEATH **Arteriosclerotic Cardiovascular Disease**

(A) DUE TO **Arteriosclerotic Cardiovascular Disease**

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **0** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED **No** 20A. AUTOPSY? (Yes or No) **No** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. **21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)** **21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)**

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) **21E. INJURY OCCURRED** **21F. HOW DID INJURY OCCUR?**

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ACTUAL SIGNATURE **Werner U. Spitz, M.D.** M.D. ASSISTANT MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type) **Werner U. Spitz, M.D.** ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **11-30-67** 23C. NAME OF CEMETERY or CREMATORY **London Park** 23D. LOCATION (City, town, or county) (State) **Baltimore, Md**

24A. DATE REC'D BY HEALTH DEPT. **NOV 29 1967** 24B. NAME OF REGISTRAR **Robert E. Farley, M.D.** 24C. FUNERAL DIRECTOR **Geo. L. Schwab Funeral Home** ADDRESS **Francis D. Miller 2101 Frederick Ave.**

DATE SIGNED **11/28/67**



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650		67 11451		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11451	
<b>CERTIFICATE OF DEATH</b>							
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Brown, Henry		11/25/67 12:55p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  33 The Johns Hopkins Hospital 601 N. Broadway Baltimore, Maryland 21205				A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 10-01 D. STREET ADDRESS (If rural, give location) 1036 Valley Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12/02/00	9. AGE (In years last birthday) 66 yrs.	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab orer		10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Brown, James				14. MOTHER'S MAIDEN NAME Thomas, Susanne			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217 07 3819		17. INFORMANT Mr Dick B B rown, same		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Oat cell ca of lung & pleural, cutaneous & cerebral metastases				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/22/19 67 to 11/25/19 67, that (I) last saw the deceased alive on 11/25/19 67 and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.							
23A. SIGNATURE Elizabeth H. Jansson				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 11/25/67	
23C. PHYSICIAN'S NAME (Type) Elizabeth H Jansson				23D. ADDRESS Johns Hopkins Hospital.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/30/67		24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. NOV 29 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR A Halstead		ADDRESS 1206 W North Ave	

Get all 20 of June 5  
planned, written, &  
written instructions

Yes

11/22

11/24

11/22

11/22/13

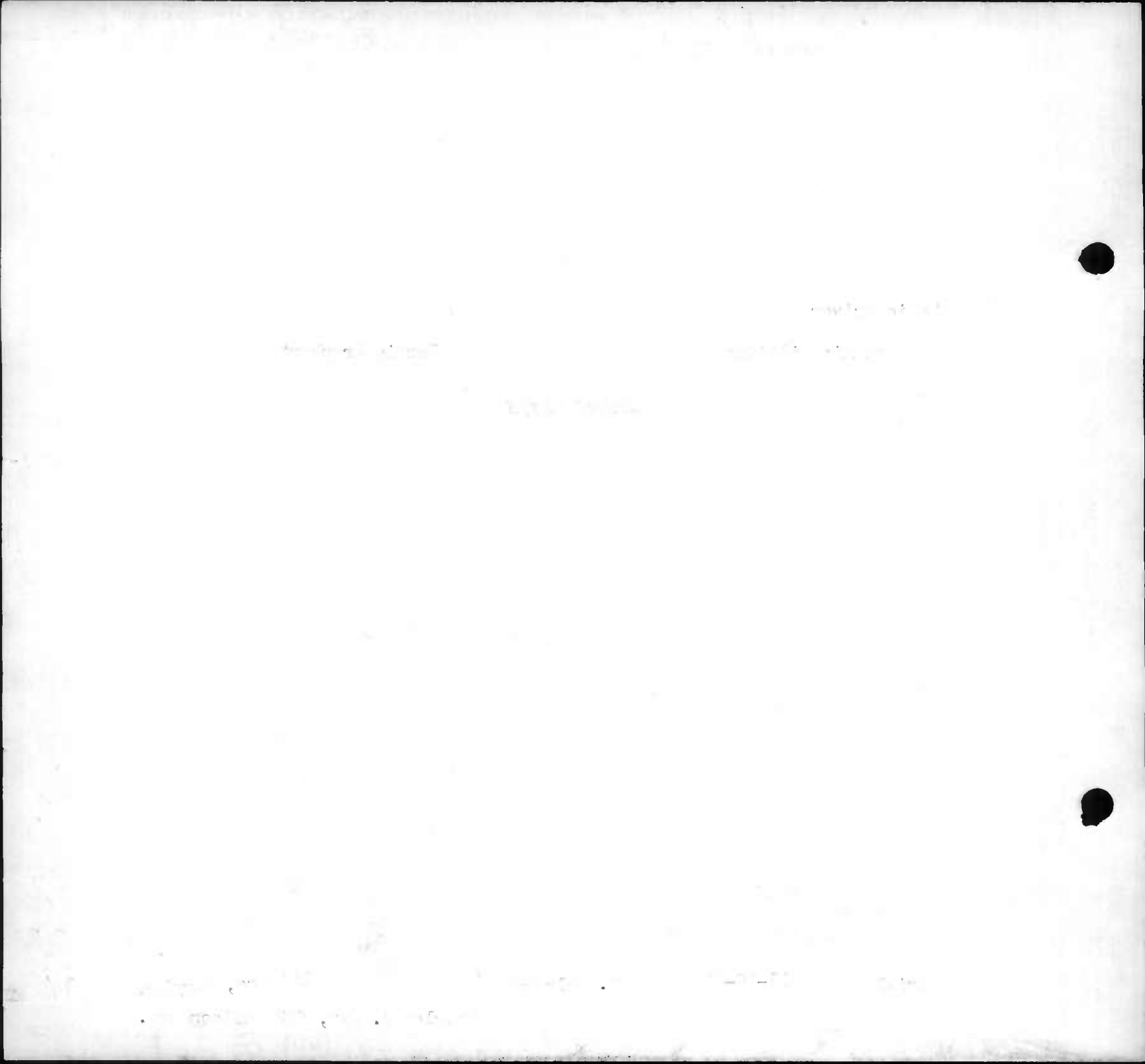
Johns Hopkins Hospital

Elizabeth H. Johnson  
Elizabeth H. Johnson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">67 11452</span>	
<div style="display: flex; justify-content: space-between;"> <span>W-452</span> <span>67 11452</span> <span>CERTIFICATE OF DEATH</span> </div>					
<b>M.E. CASE NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="float: right;">WILLIAMS, WEBSTER</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="float: right;">11-26-1967 00:45 A.M.</span>		
<b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give sheet address or location) <span style="font-size: 2em;">46</span> LUTHERAN HOSPITAL OF MARYLAND			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="float: right;">MARYLAND</span> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="float: right;">16-07</span> BALTIMORE D. STREET ADDRESS (If rural, give location) 2913 Riggs Ave.		
<b>5. SEX</b> M	<b>6. RACE</b> NEGRO	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</b> SEPARATED	<b>8. DATE OF BIRTH</b> 10/25/08	<b>9. AGE (In years last birthday)</b> 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Taxie Driver		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> —		<b>11. BIRTHPLACE</b> (State or foreign country) Virginia	
<b>12. CITIZEN OF WHAT COUNTRY?</b> U. S.			<b>13. FATHER'S NAME</b> Ananais Williams		
<b>14. MOTHER'S MAIDEN NAME</b> Fannie Erquhart			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) No		
<b>16. SOCIAL SECURITY NO.</b> 215-10-3413			<b>17. INFORMANT</b> Sarah Pross		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			<b>CAUSE OF DEATH</b> (A) <span style="font-size: 1.5em;">Gastro intestinal bleeding</span> (B) <span style="font-size: 1.5em;">? Peptic ulcers.</span> (C)		
<b>19. DATE OF OPERATION</b> 540.0 41260X			<b>20. AUTOPSY?</b> (Yes or No) No		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>			<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) Diabetic Mellitus		
<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		
<b>21E. INJURY OCCURRED</b> White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			<b>21F. HOW DID INJURY OCCUR?</b>		
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="float: right;">11-25-1967</span> <b>to</b> <span style="float: right;">11-26-1967</span> , <b>that (I) (we) last saw the deceased alive on</b> <span style="float: right;">11-26-1967</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">Khoo</span>			<b>23B. DATE SIGNED</b> 11-26-67		
<b>23C. PHYSICIAN'S NAME (Type)</b> DAVID KHOO			<b>23D. ADDRESS</b> LUTHERAN.		
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> Burial		<b>24B. DATE</b> 11-30-67		<b>24C. NAME OF CEMETERY OR CREMATORY</b> Mt. Calvary	
<b>24D. LOCATION</b> (City, town, or county) (State) Baltimore, Maryland		<b>25A. DATE REC'D BY HEALTH DEPT.</b> NOV 29 1967			
<b>25B. NAME OF REGISTRAR</b> Robert E. Farley		<b>25C. FUNERAL DIRECTOR</b> Charles R. Law, 802 Madison Ave.			



67 11453

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 11453

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

FRANCIS JOSEPH DOUGHER

2. DATE AND HOUR PRONOUNCED DEAD

November 23, 1967 6:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

517 Cathedral Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

3-25-29

9. AGE (In years  
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Pipe Fitter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Binghamton, N. Y.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Dougher

14. MOTHER'S MAIDEN NAME

Nellie Hicks

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS Binghamton  
Chase Funeral Hme. 44 Exchange St. N.Y.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Cerebrocranial injuries  
DUE TOANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

highway

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Baltimore-Washington Expressway  
6/10 mile south of Harbor Tunnel21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
11-23-67 3:55 A.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

November 24, 1967

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/27/67

23C. NAME of CEMETERY or CREMATORY

Port Crane Cem.

23D. LOCATION

(City, town, or county)

Binghamton, N.Y.

(State)

24A. DATE REC'D BY HEALTH DEPT.

NOV 29 1967

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

James M. Fields - Balto, Md.

ADDRESS

N 856.2

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

1

1/7/1

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James M. Full



B-400

67 11454

BALTIMORE CITY HEALTH DEPARTMENT

67 11454

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

*Ralph*  
**CLINTON BLUE**

2. DATE AND HOUR PRONOUNCED DEAD

**November 20, 1967 10:22 am.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

**33**  
**Johns Hopkins Hospital D.O.A.**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

**Maryland Baltimore**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

**Pierre Motel - Route 40**

5. SEX

**Male**

6. RACE

**White**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

**Single**

8. DATE OF BIRTH

**April 14, 1921**

9. AGE (In years last birthday)

**46**

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Service Man**

10B. KIND OF BUSINESS OR INDUSTRY

**U.S. Navy**

11. BIRTHPLACE (State or foreign country)

**Coopersville Michigan**

12. CITIZEN OF WHAT COUNTRY?

**U.S.A.**

13. FATHER'S NAME

**Ralph Blue**

14. MOTHER'S MAIDEN NAME

**Maude Mitchell**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

**Yes World War II**

16. SOCIAL SECURITY NO.

**376-18-3561**

17. INFORMANT

**Edward Levindotsky - 25826 Edgemoor**

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

**Arteriosclerotic Cardiovascular Disease**

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

**0**

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

**No**

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

**Edward F. Wilson**

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

**November 20, 1967**

23A. BURIAL CREMATION, REMOVAL (Specify)

**Burial**

23B. DATE

**11/26/67**

23C. NAME OF CEMETERY or CREMATORY

**Ravenna Cem.**

23D. LOCATION

**Ravenna, Michigan**

24A. DATE REC'D BY HEALTH DEPT.

**NOV 29 1967**

24B. NAME OF REGISTRAR

**Robert E. Taylor, M.D.**

24C. FUNERAL DIRECTOR

**James M. Fields - Balto., Md.**

~~Single~~

April 14, 1942

Copacabana, Michigan

George Mac U.S. Navy

Ralph Blue

Maude Mitchell

per World War II 27-18-224 Edward Lawrence 27-18-224

Department of the Army

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

Edward Lawrence

James M. Fisher, Detroit, Michigan  
General Manager, Keweenaw Peninsula, Michigan

50-62-93 GG1

J-635 67 11455

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 67 11455

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MARY B. JORDAN

2. DATE AND HOUR OF DEATH

11/24/67

4 50 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)BALTIMORE CITY HOSPITALS  
4940 EASTERN AVENUE  
BALTIMORE 21224, MARYLAND4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE

MARYLAND

B. COUNTY

BALTO, G

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

904 1st St.

#21219

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

5-28-02

9. AGE (In years  
last birthday)

65

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Domestic

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIAM

14. MOTHER'S MAIDEN NAME

MARY EDWARDS

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MD.

RECORDS: BCH 4940 EASTERN AVE. BALTO. 21224,

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION lost.

(A) DUE TO

(B) DUE TO

(C) DUE TO

Intracerebral Hemorrhage 2d.  
Arteriosclerotic Cerebrovascular  
Disease

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
WorkNot While  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/22 1967 to 11/24 1967.  
that (I) (we) lost saw the deceased alive on 11/24 1967 and that in my (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) did (did not) view the body after death.

23A. SIGNATURE

David E. Mc Beth

M.D.

Attending  
Phys.Med.  
DirectorStaff  
Phys.

23B. DATE SIGNED

11/24/67

23C. PHYSICIAN'S  
NAME (Type)

DR. DAVID E. MC BETH

M.D.

23D. ADDRESS

BALTIMORE 21224, MARYLAND

BALTIMORE CITY HOSPITALS 4940 EASTERN AVE.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 29 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

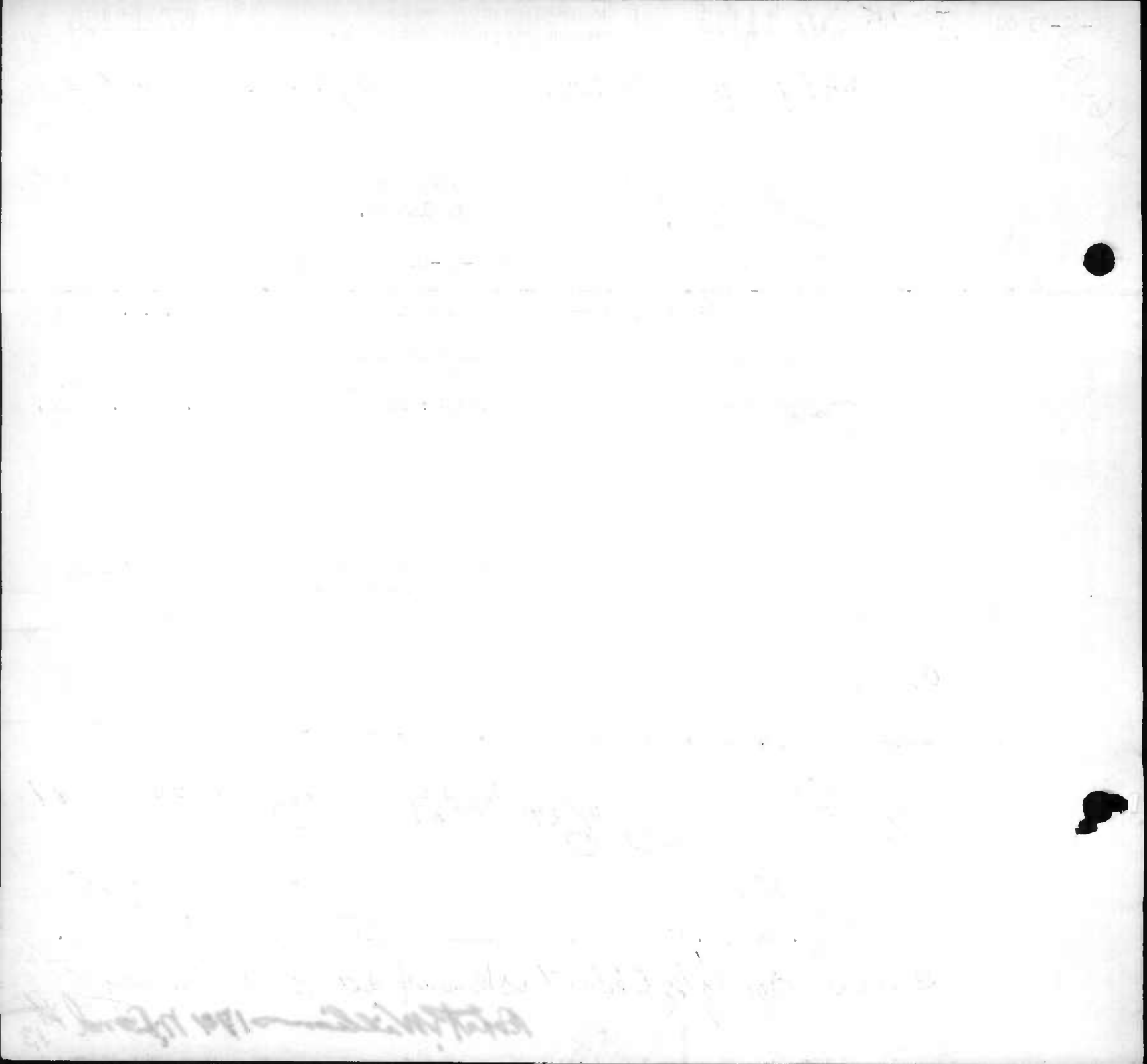
Robert E. Taylor

ADDRESS

1701 N. Bond St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-236		67 11456		Baltimore City Health Department		Registered No. 67 11456	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>MAGGIE FOSTER</b>				2. DATE AND HOUR OF DEATH <b>11/29/67</b>   <b>8:30 P M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 BONTIN HILL NURSING HOME</b>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		D. STREET ADDRESS (If rural, give location) <b>904 E. 20TH ST</b>	
5. SEX <b>F</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>8/5/97</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MARSH CALPENTER</b>				14. MOTHER'S MAIDEN NAME <b>ADDIE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-01-3672</b>		17. INFORMANT <b>Edgar Carpenter</b>		ADDRESS <b>Same</b>	
18. <b>493 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PNEUMONIA</b>				(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Tuberculosis, Dehydration</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10/18/67</b> 19 to <b>11/29/67</b> 19, that (I) (we) last saw the deceased alive on <b>11/29/67</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>[Signature]</b> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>11/29/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>HONNIS JENNALINE</b> M.D.				23D. ADDRESS <b>5514 KENNISON AV BALT</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-2-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 29 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Harry O. Wilson</b>		ADDRESS <b>1000 B. Valley Ave.</b>	

2 pages enclosed 8/21

Massachusetts  
—

Enclosure

John J. ...  
to

10/1/12

10/1/12

10/1/12

John J. ...  
12

John J. ...

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
67 11457		67 11457			
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MRS Felia Wisniewski		28 NOV 67 1 15 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
35 Chuck Home & Hospital		MD		BALTIMORE	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
F		CAUC		WIDOWED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				POLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
BRONZERT WISNIEWSKI		? UNKNOWN		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		214 34 2649		WALTER WISNIEWSKI	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) Coronary Vascular Accident		9 DAYS	
ANTECEDENT CAUSES		(B) Congestive failure			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Nov. 19 1967 to Nov. 28 1967, that (I) (we) last saw the deceased alive on Nov. 28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Corazon Z. Vergara		Nov. 28, 1967			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
CORAZON Z. VERGARA		Church Home & Hospital 100 N. Broadway Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		12/6/67		HOLY ROSARY CEMETERY BALTO	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
NOV 29 1967		R. E. Taylor		JOHN M. WEBER & SONS 401 S. CHESTER ST	

VERGARA S - VERGARA S

General: 3

X

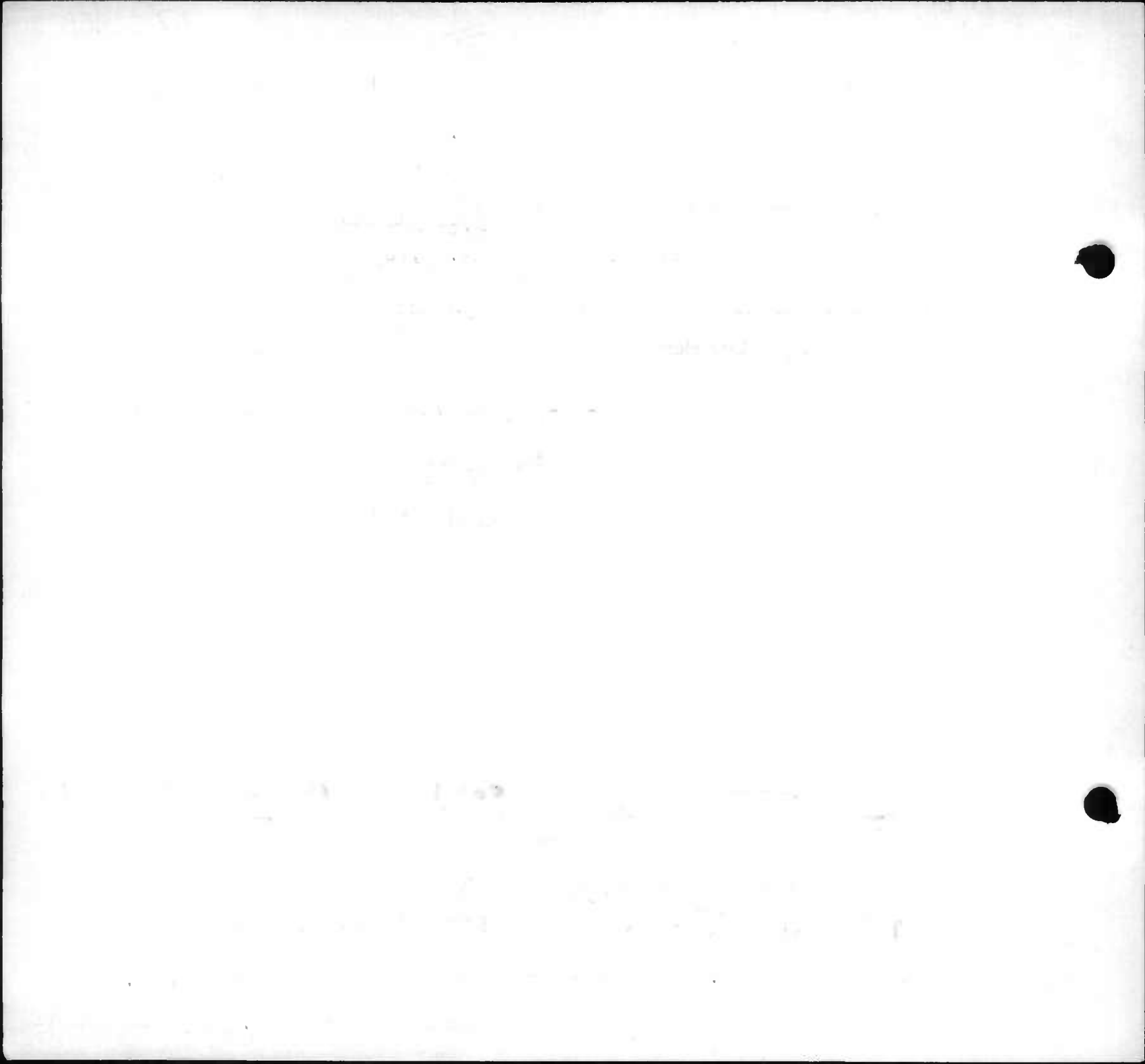
1/2 cup sugar



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-425		67 11458		BALTIMORE CITY HEALTH DEPARTMENT		67 11458	
BIRTH NO.		67 11458		CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO.				2			
1. NAME OF DECEASED (Type or Print) <u>Anthony Samuel Alexander</u>				2. DATE AND HOUR OF DEATH <u>11-28-67</u> <u>6</u> <u>P</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		If not in hospital or institution, give street address or location		A. STATE <u>Md.</u>		B. COUNTY	
<u>00 5922 Glenoak Ave</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		<u>2744</u>	
				D. STREET ADDRESS (If rural, give location) <u>5922 Glenoak Ave</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED <u>Married</u>	8. DATE OF BIRTH <u>Oct. 23, 1894</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Draftsman</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>? Alexander</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>312-03-4685</u>		17. INFORMANT <u>Mrs. Theresa M. Alexander</u>		ADDRESS <u>Same</u>	
18. <u>334X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <u>Hemiplegia</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
				(B) <u>Cerebral arteriosclerosis</u> DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>October 1966</u> to <u>Nov. 28, 1967</u> , that (I) <del>was</del> lost saw the deceased alive on <u>Nov. 25, 1967</u> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>not</del> view the body after death.							
23A. SIGNATURE <u>Donald Jandorf</u> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>11-28-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Donald Jandorf</u> M.D.				23D. ADDRESS <u>6077 Harford Rd</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/1/67.</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 29 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Talley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u>		ADDRESS <u>5305 Harford Rd</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 11459	
BIRTH NO. 67 11459		CERTIFICATE OF DEATH		67 11459	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>RUDDA, EVALD RUUDI</b>		2. DATE AND HOUR OF DEATH <b>27 November 1967 5:30 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>318 South Lehigh Street</b> <b>21224</b>		26-07	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Separated</b>	8. DATE OF BIRTH <b>9-24-1898</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Church Home</b>	11. BIRTHPLACE (State or foreign country) <b>Estonia</b>		12. CITIZEN OF WHAT COUNTRY? <b>Estonia</b>
13. FATHER'S NAME <b>Unknown Ruudi</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213 302 114A</b>	17. INFORMANT ADDRESS <b>Records: BCH-4940 Eastern Avenue 21224</b>		
18. <b>600.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>UREMIA</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CHRONIC RENAL FAILURE</b>		(B) DUE TO <b>PYELONEPHRITIS.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>HASCUD.</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>3-AUGUST 1967</b> to <b>27 November 1967</b> , that (1) (we) last saw the deceased alive on <b>27 November 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Melvyn S. Tockman</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>27 Nov. 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>Melvyn S. Tockman</b>		23D. ADDRESS <b>4940 Eastern Avenue, Baltimore, Maryland 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>12/2/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greenmount Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 29 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Tackman</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck Inc. Balto. Md.</b>	

V.S. 153

12-5-67

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

THIS CASE RELEASED AS NON-MEDICAL EXAMINER'S BY DR. KURBLOOM OF M.E. OFFICE

BALTIMORE CITY HEALTH DEPARTMENT				67 11460	
CERTIFICATE OF DEATH				Registered No. 67 11460	
BIRTH NO. M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Thomas, David H		11/27/67 10:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
33 THE JOHNS HOPKINS HOSPITAL				MARYLAND	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				BALTIMORE	
				D. STREET ADDRESS (If rural, give location)	
				2802 HILLDALE AVENUE	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MALE	NEGRO	MARRIED	12-29-1920	46	
			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
			BALTIMORE, MARYLAND		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
RICHARD THOMAS			HENRIETTA SOLLIS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Mrs. Mamie Thomas 2802 Hillside Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.11			Myocardial infarction (? inferior)		2 hours
ANTECEDENT CAUSES			(B) DUE TO		At least 3 yrs.
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11/27 1967 to 11/27 1967, that (I) (we) last saw the deceased alive on 11/27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Elizabeth H. Jansson				11/27/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
ELIZABETH H. JANSSON				JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		12-1-67		Mount Calvary Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
		Robert E. Faldut		MORTON & DYETT F.H. 1701 Laurens	
24D. LOCATION (City, town, or county) (State)		24E. LOCATION (City, town, or county) (State)		24F. LOCATION (City, town, or county) (State)	
A.A. CO., MARYLAND		A.A. CO., MARYLAND		A.A. CO., MARYLAND	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11461 <b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		Registered No. 67 11461	
BIRTH NO. 67 11461 M.E. CASE NO.		2. DATE AND HOUR OF DEATH 11/27/67 8-15 A.M.	
1. NAME OF DECEASED (Type or Print) <b>LINSON EFFIE</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Lutheran Hospital of Maryland</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1603 Hilton St</b>	
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>5-16-1895</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>72</b>
11. BIRTHPLACE (State or foreign country) <b>Spartanburg, S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Wallace</b>		14. MOTHER'S MAIDEN NAME <b>Cleo Wallace</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs. Effie Williams</b>
		ADDRESS <b>1603 N. Hilton</b>	
18. <b>2865 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO <b>Dehydration</b> (B) DUE TO <b>Malnutrition</b> (C)	
		INTERVAL BETWEEN ONSET AND DEATH <b>few months</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-6-1967</b> to <b>11-27-1967</b> , that (I) (we) last saw the deceased alive on <b>11-27-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Anil M. Joshi</b>		23B. DATE SIGNED <b>11-27-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>ANIL M. JOSHI</b>		23D. ADDRESS <b>Lutheran Hospital of Maryland, 730 Ashburton St, Baltimore, MD 21206</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>12-2-67</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Balto. Md</b>
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 29 1967</b>	25B. NAME OF REGISTRAR <b>Robert E. Fairbanks</b>	25C. FUNERAL DIRECTOR <b>Morton E. Dyett F.H.</b>	
		ADDRESS <b>1701 Laurens</b>	

1882

1883

James Waller

1884

Geo Waller

1885

Deborah

1886

1887

1888

1889

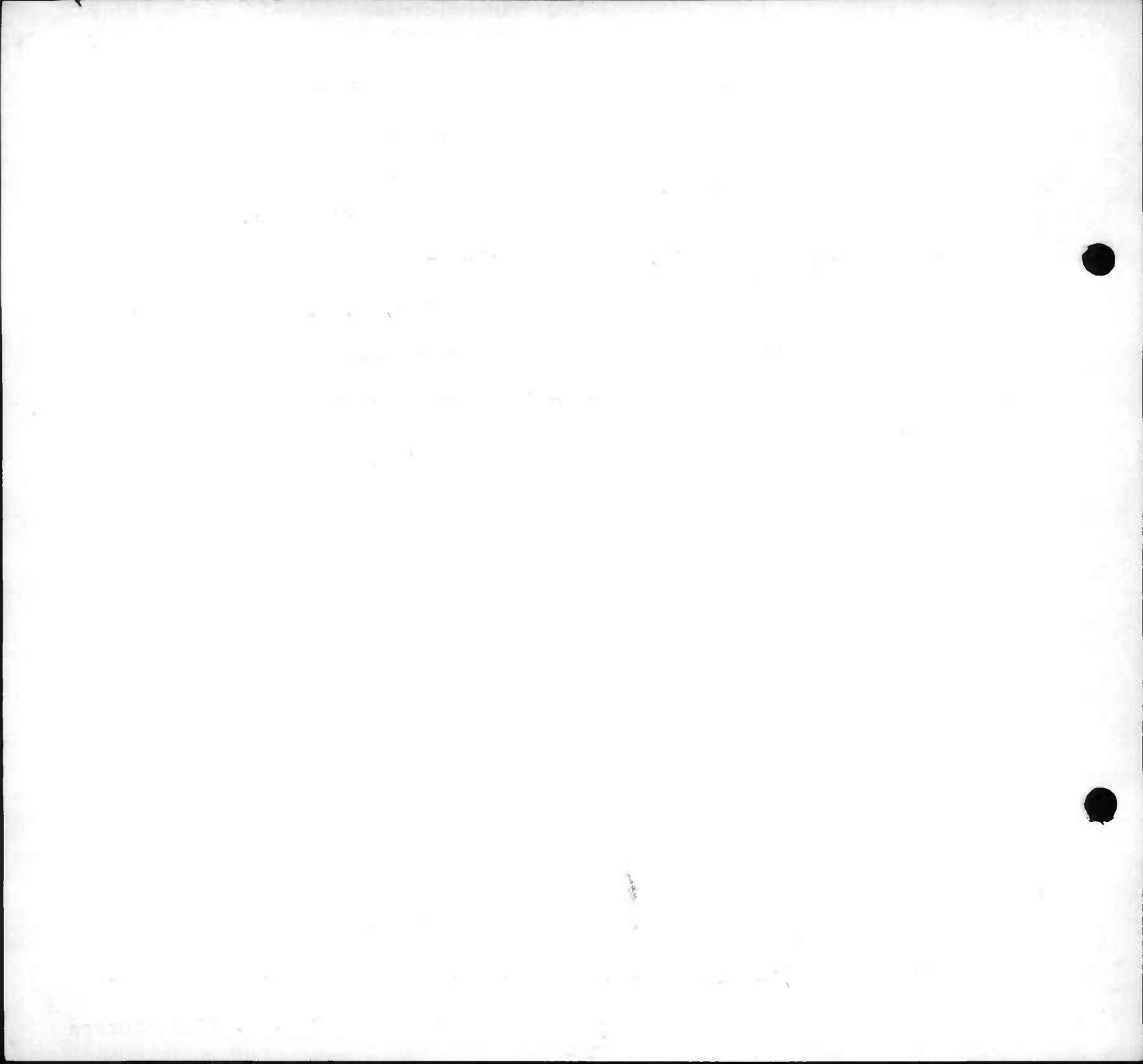
1890



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 11462	
BIRTH NO. 67 11462		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Frank Gaston</b>		2. DATE AND HOUR OF DEATH <b>11-25-67</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>3008 Presstman St.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>3008 Presstman St.</b>			
5. SEX <b>Male</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Wid.</b>	8. DATE OF BIRTH <b>3-16-1909</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Chester, S. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles Gaston</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Gaston</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>245-26-6152</b>	17. INFORMANT ADDRESS <b>Sarah Stevenson 3008 Presstman St.</b>		
18. <b>420.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <b>Reber-Silvestre Heart Disease</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-8-1967</b> to <b>11-25-1967</b> , that (I) (we) last saw the deceased alive on <b>10-4-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Bernard Harris</b> M.D.				23B. DATE SIGNED <b>11/28/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>Bernard Harris</b>		23D. ADDRESS <b>1202 N. Caroline St.</b> M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-29-67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>	
		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 28 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Feltman</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Morton &amp; Dyett F. H. 1701 Laurens</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11463		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11463	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John Joseph Mack		2. DATE AND HOUR OF DEATH Nov. 28, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital 42		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore		5. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
6. STREET ADDRESS (If rural, give location) 5425 Fairlawn Ave.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH Jan. 28, 1894	
9. AGE (In years last birthday) 73 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		11. BIRTHPLACE (State or foreign country) Salem, New Jersey	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Mary Clarke	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W #1		16. SOCIAL SECURITY NO. 212-10-9234		17. INFORMANT ADDRESS Mrs. Lorraine Mack, 5425 Fairlawn Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I Acute myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 15 minutes		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary artery disease Several years		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 1966 to Nov 28 1967, that (I) (we) last saw the deceased alive on Oct 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Seymour H. Rubin, M.D.		23B. DATE SIGNED 11/29/67		23C. PHYSICIAN'S NAME (Type)	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/1/1967		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. NOV 29 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR B. Vernon Lemmon		25D. ADDRESS 4611 Park Heights Ave.			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11464

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)  
MARY

SVATEY

2. DATE AND HOUR PRONOUNCED DEAD

November 27, 1967 10:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3101 Brendan Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

July 14 1897

9. AGE (In years  
last birthday)

70

10. Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

At home

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

Yugoslavia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Kuzma Srein

14. MOTHER'S MAIDEN NAME

Eva ?/

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

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16. SOCIAL  
SECURITY NO.

213-078802

17. INFORMANT

Andrew Svatey 3101 Brendan Ave.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

11/28/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

12-1-67

23C. NAME of CEMETERY or CREMATORY

St. Andrews Cemetery

23D. LOCATION (City, town, or county) (State)

German Hill Rd. Maryland

24A. DATE REC'D BY HEALTH DEPT.

NOV 29 1967

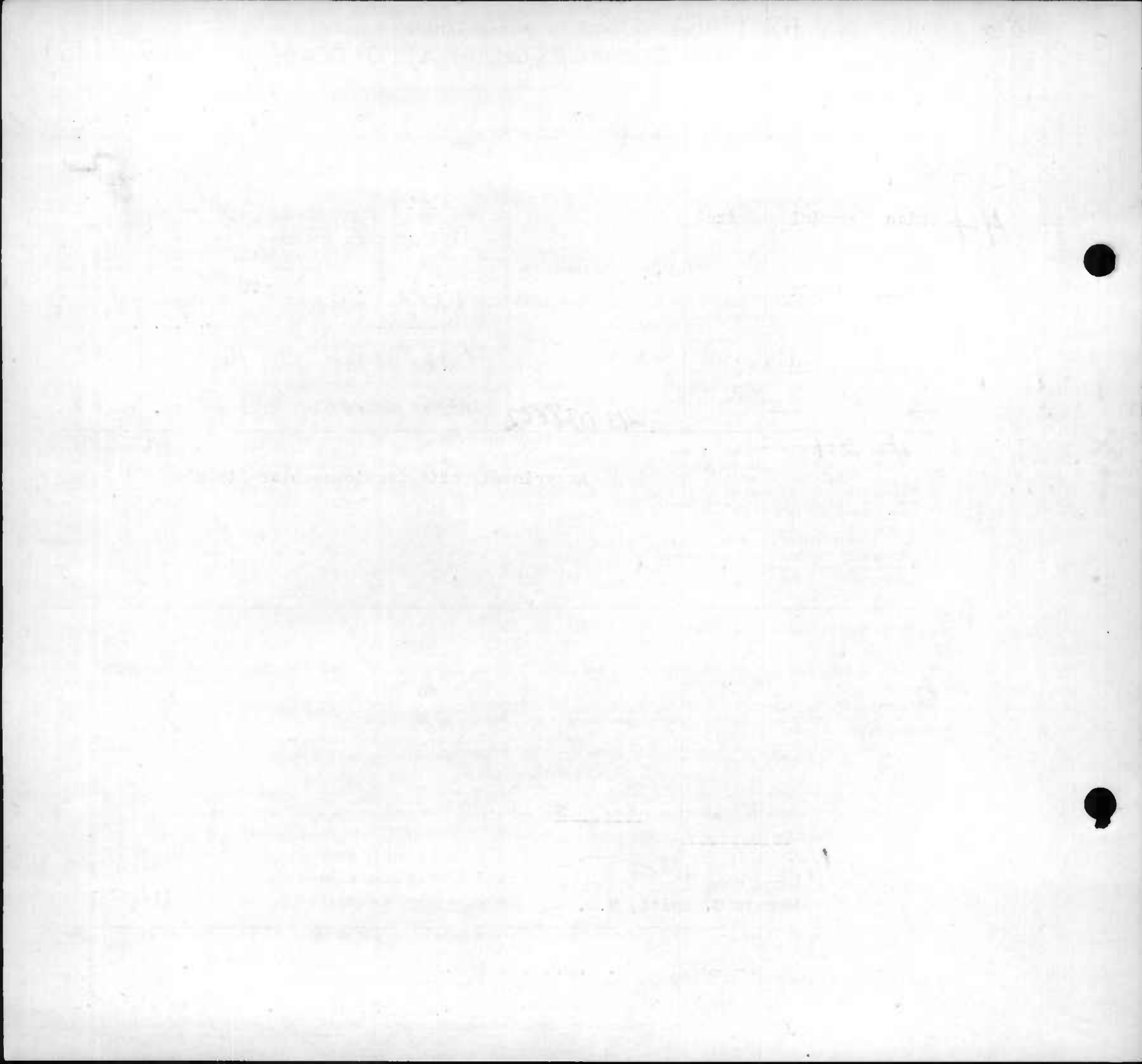
24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Dippel Brothers Inc. 7110 Belair Rd.

ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11465		BALTIMORE CITY HEALTH DEPARTMENT		67 11465	
BIRTH NO.		M.E. CASE NO.		Registered No.	
1. NAME OF DECEASED (Type or Print) <b>RUTH N. EVANS</b>		2. DATE AND HOUR OF DEATH <b>NOV 27, 1967 10:10 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 HOUSE IN THE PINES BELAIR RD.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 11-02</b>			
5. SEX <b>FEMALE</b>		6. RACE <b>CAUCASIAN</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	
8. DATE OF BIRTH <b>10-26-1892</b>		9. AGE (In years last birthday) <b>75</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN A. EVANS</b>	
14. MOTHER'S MAIDEN NAME <b>MARGARET BENJAMIN</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-14-1061</b>	
17. INFORMANT <b>GLADYS STINE</b>		ADDRESS <b>6522 WALTER BLVD BALTO</b>		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinomatosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos. +</b>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		21. DATE OF OPERATION <b>0</b>		22. CONDITION FOR WHICH OPERATION WAS PERFORMED	
23. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		25. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
26. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		27. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		28. HOW DID INJURY OCCUR?	
29. I certify that (I) (this hospital) attended the deceased from <b>6/22 1967</b> to <b>11/27 1967</b> , that (I) (we) last saw the deceased alive on <b>11/24 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
30. SIGNATURE <b>Albert B Bradley</b>		31. DATE SIGNED <b>11/28/67</b>		32. PHYSICIAN'S NAME (Type) <b>ALBERT B BRADLEY M.D.</b>	
33. ADDRESS <b>4900 BELAIR RD. BALTO. MD.</b>		34. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		35. DATE <b>11/28/67</b>	
36. NAME OF CEMETERY or CREMATORY <b>LOU DON PARK CEM.</b>		37. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>		38. DATE REC'D BY HEALTH DEPT. <b>NOV 29 1967</b>	
39. NAME OF REGISTRAR <b>ALBERT B. Bradley</b>		40. FUNERAL DIRECTOR <b>THE DIPPEL BROTHERS</b>		41. ADDRESS <b>3110 BELAIR RD.</b>	

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T-512		67 11466		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 67 11466	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
MURIEL J. THOMPSON			November 25, 1967 14:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
28 U.S. Public Health Service Hospital			Maryland Baltimore		
			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
			Baltimore 21224		
			D. STREET ADDRESS (If rural, give location)		
			7736 Wynbrook Rd.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Female	White	Married	May 23, 1918	49	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housewife			Oklahoma		U. S. A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Lon Seitz			Martha ?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT (Husband) ADDRESS
No			579-180-044		Balto. Md. 21224
			William H. Thompson, 7736 Wynnbrook Rd.		
18. E 904.0			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, esthenic, etc. It means the disease, injury or complication which caused death.)			(A) Subdural hematoma DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
11-22-67		Subdural hematoma		Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Home		7736 Wynbrook Rd., Baltimore County	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
11-20 or 11-21-67		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Fell at home	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type)			DATE SIGNED		
Charles S. Springate, M.D.			11-25-67		
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		11/28/67		Balto. National Cemetery	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
NOV 29 1967		Robert E. Farley, M.D.		John J. Duda, 7922 Wise Ave. Dundalk, Md.	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/1/81 BY SP-6 JRS/STW

251-100-000

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 11467	
BIRTH NO. <b>B-450</b>		67 11467		CERTIFICATE OF DEATH	
M.E. CASE NO.		Registered No. <b>67 11467</b>			
1. NAME OF DECEASED (Type or Print) <b>Nola Bellamy</b>		2. DATE AND HOUR OF DEATH <b>Nov. 27, 1967 6:50 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>42 SINAI Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, (if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore - Dundalk 53-00</b> D. STREET ADDRESS (If rural, give location) <b>1904 Searles Rd</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>11/26/48</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>Calvin Hawkins</b>		14. MOTHER'S MAIDEN NAME <b>Alice Michaels</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-0864B</b>		17. INFORMANT (Son) <b>Dundalk, Md. 21222</b> <b>Mr. Robert Bellamy, 1930 Eastfield Rd.</b>	
18. <b>784.51</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Aspiration</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>- 20 minutes</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO <b>Massive hematemesis</b> <b>20 minutes</b>	
(B) DUE TO		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Nov. 25 1967</b> to <b>Nov. 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 27 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Richard T. Bass</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Nov. 27, 1967</b>	
23C. PHYSICIAN'S NAME (Type) <b>Richard T. Bass</b>		23D. ADDRESS M.D. <b>Sinai Hospital, Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/30/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 29 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Searles</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>	

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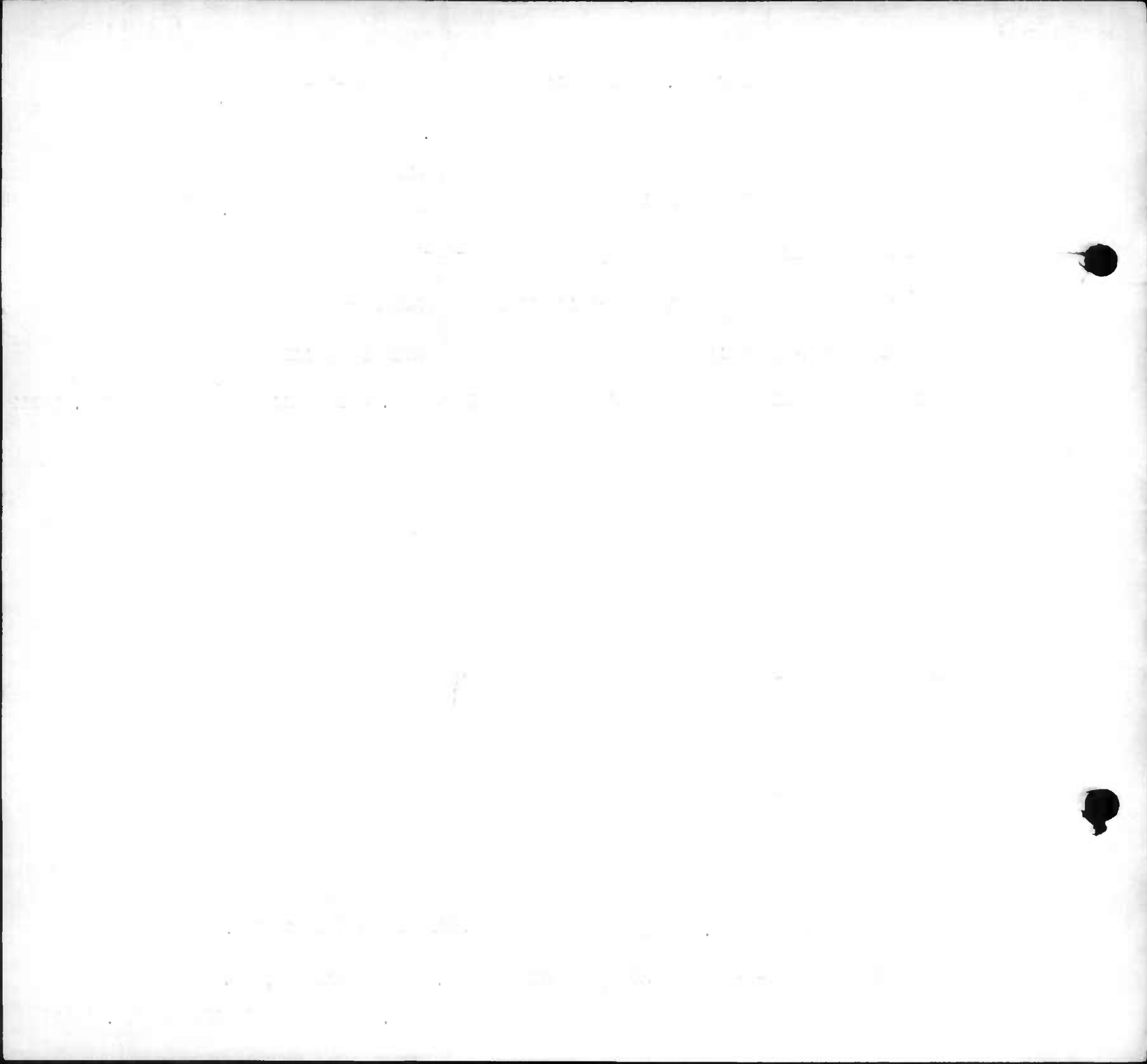
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

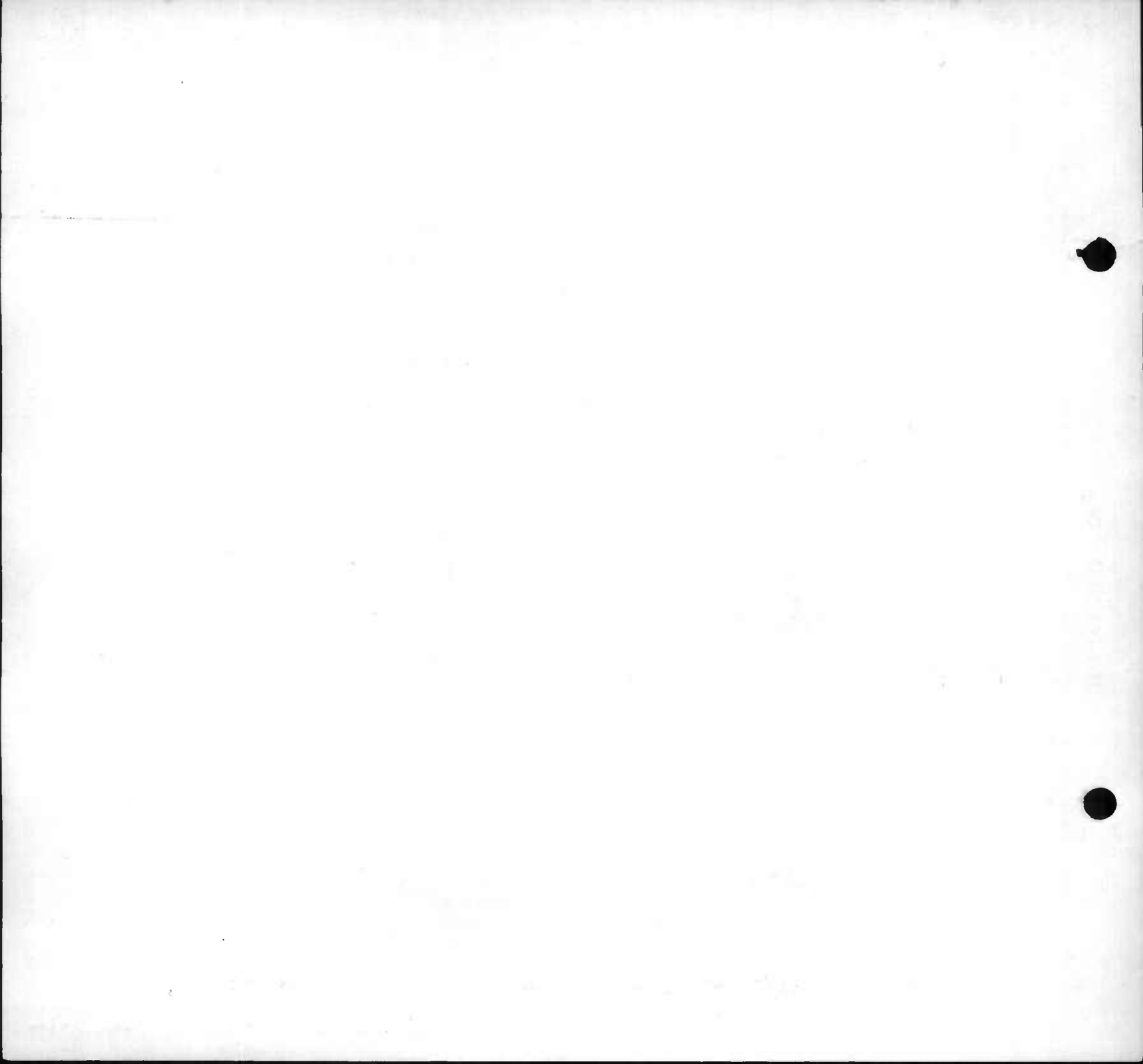
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO.		67 11468				CERTIFICATE OF DEATH		Registered No. 67 11468	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DANTE R. SCIARRETTA				2. DATE AND HOUR OF DEATH 11-28-67			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 JOHNS HOPKINS HOSPITAL						C. CITY OR TOWN (If outside city limits, give RURAL and give township) BALTIMORE			
						D. STREET ADDRESS (If rural, give location) 1653 WOODBOURNE AVE. 21212			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 4-13-20	9. AGE (In years last birthday) 47	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARTENDER		10B. KIND OF BUSINESS OR INDUSTRY WOODLAWN COUNTRY CLUB		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME MICHAEL SCIARRETTA				14. MOTHER'S MAIDEN NAME MARIA PERROTTI					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 212148349		17. INFORMANT MILDRED M. SCIARRETTA		1653 ADDRESS WOODBOURNE AVE. 21212			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION INTERACTION DUE TO DISEASE OF HEART DUE TO INTERACTION DUE TO INTERACTION						INTERVAL BETWEEN ONSET AND DEATH 10 minutes			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HDW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1963 to Nov 28 1963, that (I) (we) last saw the deceased alive on Nov 27 1963 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
23A. SIGNATURE Seymour H. Rubin				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 11/28/63			
23C. PHYSICIAN'S NAME (Type) SEYMOUR H. RUBIN				23D. ADDRESS 5415 PARKS HEIGHTS AVE.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-1-67		24C. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEM.		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.			
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR HOWARD H. HUBBARD		25D. ADDRESS 4107 WILKENS AVE. 21229			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="font-size: 2em; float: left; margin-right: 10px;">W-4101</div> <div style="text-align: center;"> <div style="font-size: 1.5em;">67 11469</div> <div style="font-size: 1.2em;">BALTIMORE CITY HEALTH DEPARTMENT</div> <div style="font-size: 1.5em;">CERTIFICATE OF DEATH</div> </div> <div style="float: right; text-align: right;"> Registered No. <u>402-264</u>  <div style="font-size: 1.5em;">67 11469</div> </div>	
BIRTH NO. <span style="float: right;">2. DATE AND HOUR OF DEATH</span> M.E. CASE NO. <span style="float: right;">11/27/67 12:45 A.M.</span> 1. NAME OF DECEASED (Type or Print) <u>ANNA L. WOLF</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION  <u>SINAI HOSPITAL OF BALTIMORE</u> </div> <div> (If not in hospital or institution, give street address or location) </div> </div>	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>2044 Walbrook Avenue</u>	
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>DIVORCED</u>	8. DATE OF BIRTH <u>7/29/21</u> 9. AGE (In years last birthday) <u>46</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITRESS</u> 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
10B. KIND OF BUSINESS OR INDUSTRY <u>MARY'S BAR</u> 13. FATHER'S NAME <u>ELMER B. BASSLER</u> 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>	14. MOTHER'S MAIDEN NAME <u>ELSIE L. TRIPLET</u> 16. SOCIAL SECURITY NO. <u>?</u> 17. INFORMANT <u>ELMER A. BASSLER-4307 DANLOU DRIVE</u> ADDRESS <u>#7</u>
18. <u>581.0 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Candida Albicans Septicaemia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Biliary Cirrhosis with hepatic failure</u>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>II</u>	
19A. DATE OF OPERATION <u>11/15/67</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Suspected Jaundice - CA. Pancreas</u> 20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?	
22. I certify that <u>we</u> (this hospital) attended the deceased from <u>11/13</u> 19 <u>67</u> to <u>11/27</u> 19 <u>67</u> , that <u>we</u> last saw the deceased alive on <u>11/27</u> 19 <u>67</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) <u>did not</u> view the body after death.	
23A. SIGNATURE <u>[Signature]</u> M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> 23B. DATE SIGNED <u>11/27/67</u> 23C. PHYSICIAN'S NAME (Type) <u>D. J. PRADHAN</u> M.D. <u>Sinai Hospital of Baltimore</u> 23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>11/30/67</u> 24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u> 24D. LOCATION (City, town, or county) (State) <u>Windsor Mill Rd, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 30 1967</u> 25B. NAME OF REGISTRAR <u>Robert E. Farley</u> 25C. FUNERAL DIRECTOR <u>Austin E. Donovan</u> ADDRESS <u>3818 Roland Ave</u>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 11470	
BIRTH NO. 67 11470		<b>CERTIFICATE OF DEATH</b>		67 11470	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>IDA SULLIVAN</b>		2. DATE AND HOUR OF DEATH <b>11-27-67</b> <b>7 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence, before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL OF MD. 730 ASHBURTON ST. BALTIMORE, MD 21216</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>2905 LOUISIANA AVE LOUISIANA</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>3-10-10</b>	9. AGE (In years last birthday) <b>57</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Morris</b>		14. MOTHER'S MAIDEN NAME <b>Sarah</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-16-0192</b>		17. INFORMANT <b>CHART</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>199.2 I MALIGNANCY (CARCINOMATOSIS)</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No.</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-15-1967</b> to <b>11-27-1967</b> , that (I) (we) last saw the deceased alive on <b>11-27-1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>S. Aziz</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/27/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>S. AZIZ</b>		23D. ADDRESS <b>LUTHERAN HOSPITAL OF MD. 730 ASHBURTON ST. BALTIMORE, MD 21216</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11/29/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Carmel</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>NOV 30 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>Sydney S. Lewis &amp; Son, INC</b>			

Received

Wm. H. Jones  
Cash

Wm. H. Jones

11/20/11

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>67 11471</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 11471</b>	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>JOHN LOUIS BROWN</b>			2. DATE AND HOUR OF DEATH <b>11-28-67 8:55 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIV. OF MD HOSPITAL</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 20-04</b>		
D. STREET ADDRESS (If rural, give location) <b>2606 HAFER ST 21223</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>W</b>	8. DATE OF BIRTH <b>8-21-07</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ROOPER, PAINTER Home Improvement Co.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>THOMAS BROWN</b>		14. MOTHER'S MAIDEN NAME <b>MARY R. Selby</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES W.W.II</b>		16. SOCIAL SECURITY NO. <b>214-03-4633</b>		17. INFORMANT ADDRESS <b>hosp chart.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>570.5+1 199.2</b>			CAUSE OF DEATH (A) <b>Squamous cell carcinoma of the lung</b> DUE TO (B) <b>with liver, small bowel and mesenteric metastases and perforation with peritonitis</b> DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>11-17-67</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Small bowel obstruction</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>November 1, 1967</b> to <b>November 28, 1967</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>November 28, 1967</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(We)</b> <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Charles S. Harrison</b>				23B. DATE SIGNED <b>11-28-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>CHARLES S. HARRISON</b>				23D. ADDRESS <b>UNIVERSITY OF MARYLAND HOSP.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/1/67</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Glen Burne Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 30 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkus</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John J. Cowan, Sr. Inc. 901 Mallin St. Balto Md.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11472

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

67 11472

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

WHITE C. BERNARDINE

2. DATE AND HOUR OF DEATH

11-27-67

4:15 AM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(If not in hospital or institution, give street  
address or location)

44 UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE  
B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

414 CEDARCROFT RD.

5. SEX

F

6. RACE

WHITE

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
never married

8. DATE OF BIRTH

07-28-01

9. AGE (In years  
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.  
Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

Accountant

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIAM WHITE

14. MOTHER'S MAIDEN NAME

SARAH ODEA

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

none

16. SOCIAL  
SECURITY NO.

212-09-8911

17. INFORMANT

ADDRESS

Grace White 414 Cedarcroft Rd.

18. 331X I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Cerebral Hemorrhage

(B) DUE TO

Hypertension  
Arteriosclerotic Vascular Disease

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

2 days

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐

Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-28-67 1967 to 11-27 1967.  
that (I) (we) last saw the deceased alive on 11-27 1967 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Paul V. Desjardins

M.D.

Attending  
Phys. ☐

Med.  
Director ☐

Staff  
Phys. ☒

23B. DATE SIGNED

11-27-67

23C. PHYSICIAN'S  
NAME (Type)

PAUL V. DESJARDINS, M.D.

23D. ADDRESS

M.D.

UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

11/30/67

24C. NAME OF CEMETERY or CREMATORY

New Cathedral Cemetery

24D. LOCATION

(City, town, or county)

(State)

Old. Frederick Rd. Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

NOV 30 1967

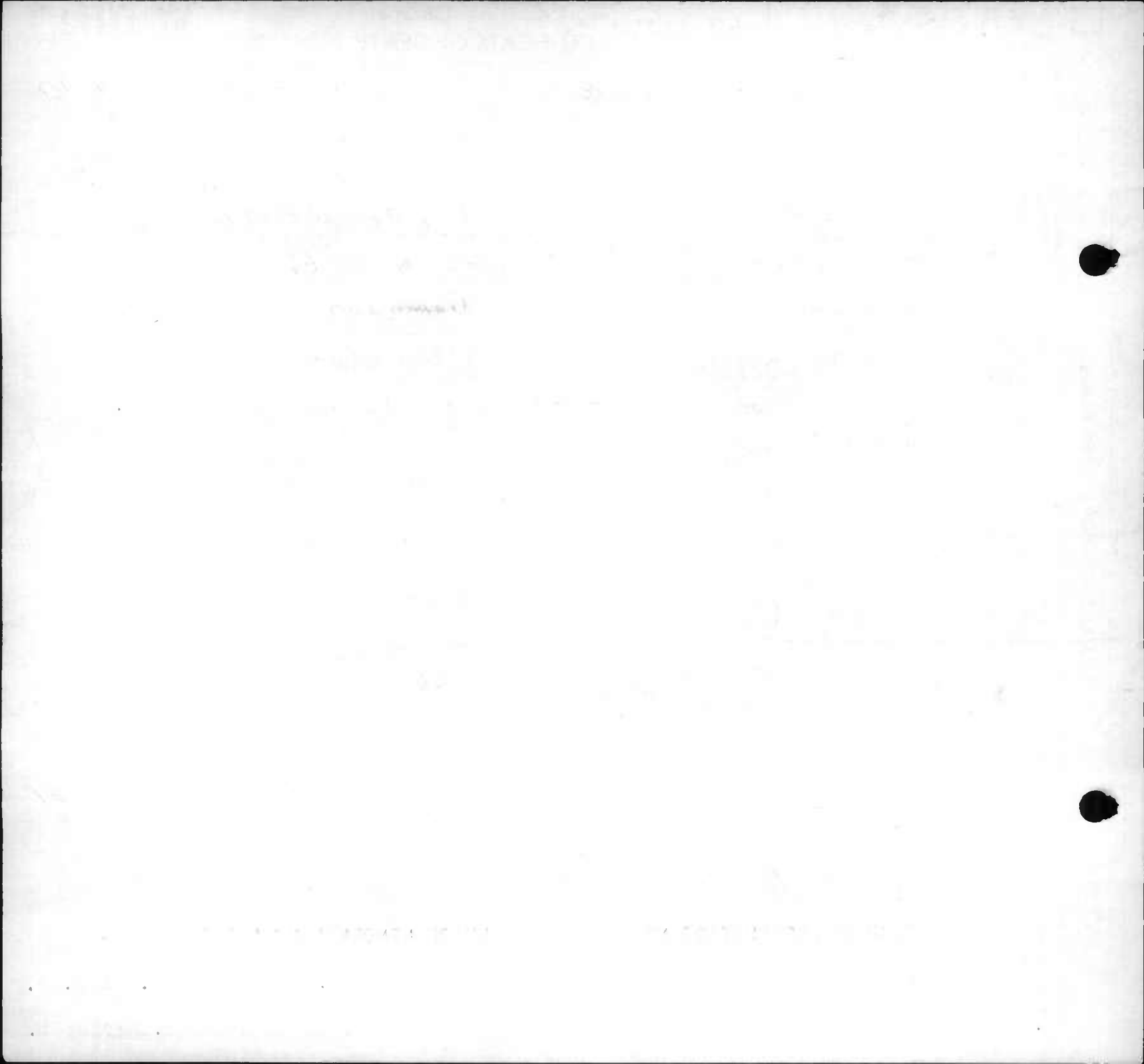
25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

KRAUSE FUNERAL HOME 1216S. Charles St.



FUNERAL DIRECTOR: IMPORTANT

50-04-19 LB 1-420 67 11473

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 11473	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. (WOLSKI) 67 11473</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
M.E. CASE NO. 67 11473					
1. NAME OF DECEASED (Type or Print) <b>WOLSKI, MARY</b>			2. DATE AND HOUR OF DEATH <b>27 November 1967 9:30 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND 21224</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		
D. STREET ADDRESS (If rural, give location) <b>322 S. ANN STREET</b>			E. STREET ADDRESS (If rural, give location)		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>3-18-1886</b>	9. AGE (In years last birthday) <b>81</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMSTRESS</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>TAILORING CO.</b>		
11. BIRTHPLACE (State or foreign country) <b>POLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>VINCENT GLOWACKI</b>			14. MOTHER'S MAIDEN NAME <b>MAGDALENA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO.</b>			16. SOCIAL SECURITY NO. <b>335-10-4204</b>		
17. INFORMANT <b>BALTIMORE CITY HOSPITALS</b>			ADDRESS <b>RECORDS: 4940 EASTERN AVENUE BALTO., MD. 21224</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>422.14 + 008X</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CVA</b> <b>ASCVD</b>			INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>RA., Pos. Tbc.</b>		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>26 August 1967</b> to <b>27 November 1967</b> , that (I) (we) last saw the deceased alive on <b>27 November 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Melvyn L. Tockman</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>27 Nov. 1967</b>
23C. PHYSICIAN'S NAME (Type) <b>MELVYN L. TOCKMAN M.D.</b>			23D. ADDRESS <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE BALTO., MD. 21224</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>12-2-67</b>	24C. NAME OF CEMETERY or CREMATORY <b>ST. ADALBERT'S CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>NILES (COOKS COUNTY) ILLINOIS</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 30 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkman</b>		25C. FUNERAL DIRECTOR <b>W. FIALKOWSKI</b>	
				ADDRESS <b>2007 EASTERN AVE. BALTO. MD. 21231</b>	

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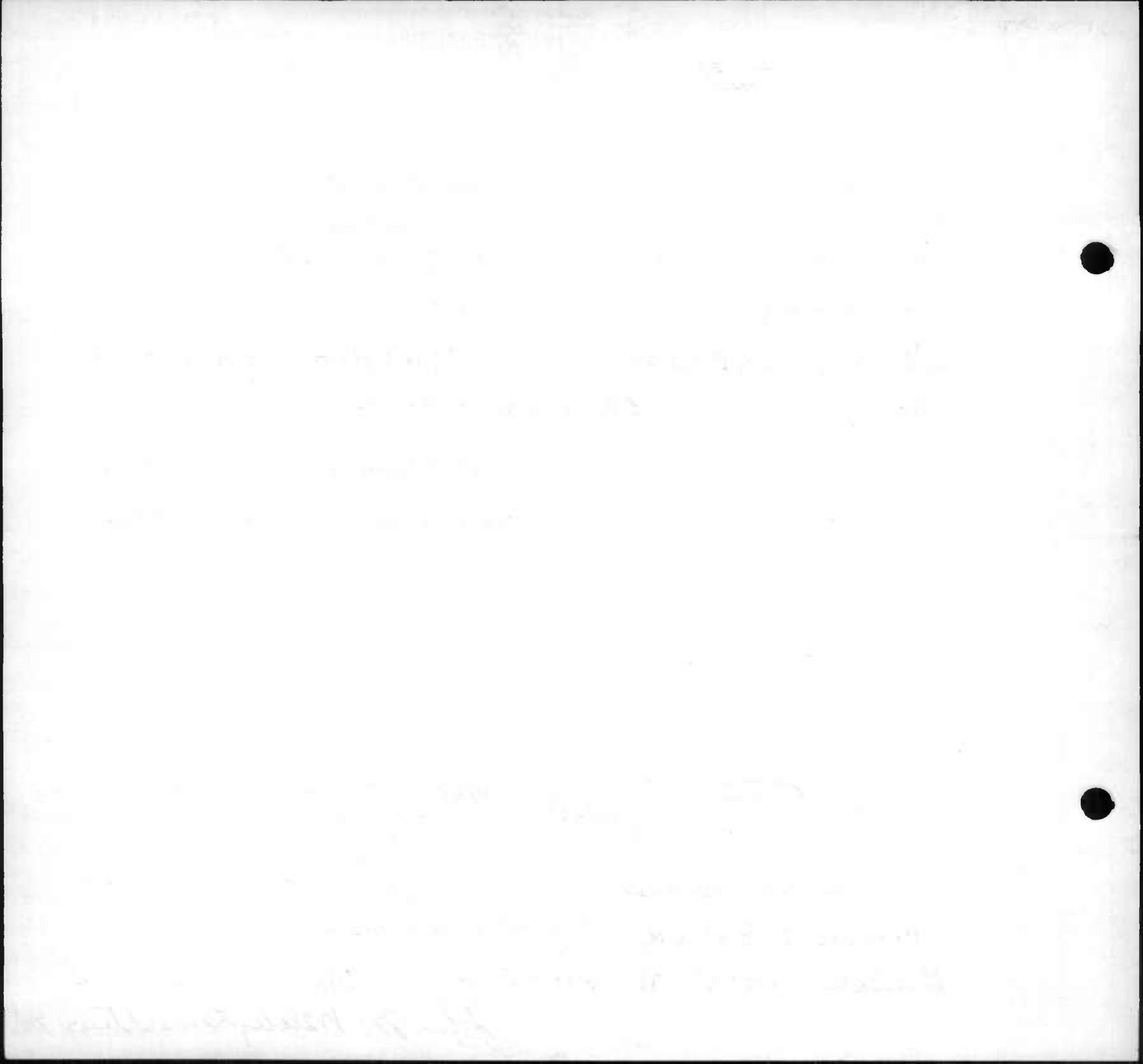
7-28-1962



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
67 11474					CERTIFICATE OF DEATH					Registered No. 67 11474									
BIRTH NO.										M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <b>LACEY</b> <b>COAD, W.</b>										2. DATE AND HOUR OF DEATH <b>11/25/67</b> <b>12 50 P</b> M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>St Mary's</b>									
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSP</b> <b>44</b>										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>CHARLOTTE HALL</b> <b>68-00</b>									
D. STREET ADDRESS (If rural, give location)																			
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M</b>		8. DATE OF BIRTH <b>6/9/02</b>		9. AGE (in years last birthday) <b>65</b>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SCHOOL TEACHER</b>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <b>TENN</b>					12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>				
13. FATHER'S NAME <b>JOHN WILKERSON</b>										14. MOTHER'S MAIDEN NAME <b>CYNTHIA JERNIGAN</b>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>579-14-5906</b>					17. INFORMANT <b>HUSBAND</b>					ADDRESS <b>SAME</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>AC. MYOCARDIAL INFARCT</b> <b>4 hrs</b>										INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.																			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION <b>0</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <b>11/25</b> 19 <b>67</b> to <b>11/25</b> 19 <b>67</b> , that (I) <u>(we)</u> last saw the deceased alive on <b>11/25</b> 19 <b>67</b> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.																			
23A. SIGNATURE <b>Charles S. Brown</b>										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <b>11/25/67</b>				
23C. PHYSICIAN'S NAME (Type) <b>CHARLES S. BROWN</b>										23D. ADDRESS M.D. <b>UNION MEMORIAL HOSPITAL</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>11/28/67</b>					24C. NAME OF CEMETERY or CREMATORY <b>ALL FAITH CEM.</b>					24D. LOCATION (City, town, or county) (State) <b>CHARLOTTE HALL, MD</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 30 1967</b>					25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>					25C. FUNERAL DIRECTOR <b>John M. Welch, Leonard Town MD</b>					ADDRESS				



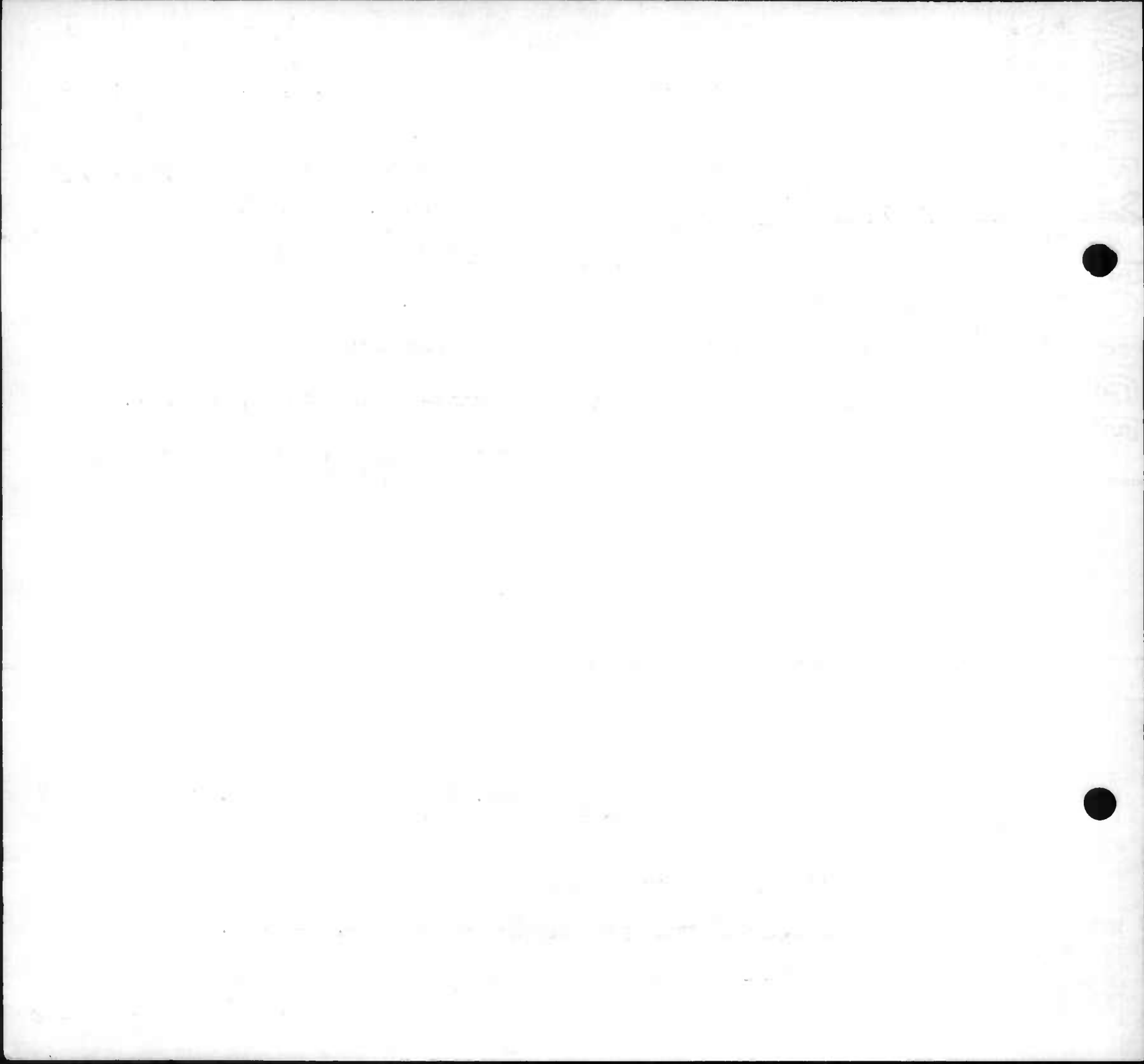
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

22361

RGB

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 11475		67 11475	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Marion Lee Jester			Nov. 28, 1967 5:10 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  US Public Health Service Hospital 3100 Wyman Pk. Drive			A. STATE Va.		
			B. COUNTY		
5. SEX F			6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow
8. DATE OF BIRTH 3/23/05			9. AGE (In years last birthday) 62		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Joshua Reynolds		
14. MOTHER'S MAIDEN NAME Marion Burch			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None		
16. SOCIAL SECURITY NO. ?			17. INFORMANT Records- US PHS Hospital, Balto, Md.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  Probable acute myocardial infarct (A) DUE TO  INTERVAL BETWEEN ONSET AND DEATH Terminal  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO (C)  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 27 19 67 to Nov. 28 19 67, that (I) (we) last saw the deceased alive on Nov. 28 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alan R. Butte M.D.					23B. DATE SIGNED 11/28/67
23C. PHYSICIAN'S NAME (Type) Alan R. Butte M.D. SA SURG.					23D. ADDRESS US PHS Hospital, Balto, Md.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-1-67		24C. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	
24D. LOCATION (City, town, or county) (State) Chincoteague, Virginia					
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Salzer Funeral Home, Chincoteague, Virginia	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

HENRIETTA

JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

November 28, 1967 10:10 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

6 N. Stockton St. (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6 N. Stockton St.

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Harrison

14. MOTHER'S MAIDEN NAME

Eliza Fuller

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS  
M's Henrietta Johnson 422 Mt Holley

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
m. WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

11/28/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

12-1-67

23C. NAME OF CEMETERY or CREMATORY

Western Star Cem.

23D. LOCATION

(City, town, or county)

(State)

Balto. Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

NOV 30 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

(Mrs) Frances A. Hemley

ADDRESS

578 W. Biddle

WALFORD  
JAN 19 1964

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 67 11477 CERTIFICATE OF DEATH

Registered No. 67 11477

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
 (Type or Print)

GEORGE RUDROFF

2. DATE AND HOUR OF DEATH

11-8-67 1 4 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Lutheran Hospital of Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
 A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4012 Maine Ave.

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED  
 WIDOWED, DIVORCED (specify)

Sing

8. DATE OF BIRTH

9. AGE (In years last birthday)

78

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) C.V.A.

10 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) A.S.C.V.D.

?

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10 - 31 - 19 67 to 11 - 8 - 19 67, that (I) (we) last saw the deceased alive on 11 - 8 - 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Anil M. Joshi

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11-8-67

23C. PHYSICIAN'S NAME (Type)

ANIL M. JOSHI

M.D.

23D. ADDRESS

Lutheran Hospital of Maryland  
 4012 Maine Ave. Baltimore, MD 21216

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

11-27-67

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

NOV 30 1967

25B. NAME OF REGISTRAR

Robert E. Fairman

25C. FUNERAL DIRECTOR

MORTUARY SERVICE

ADDRESS

BCHD

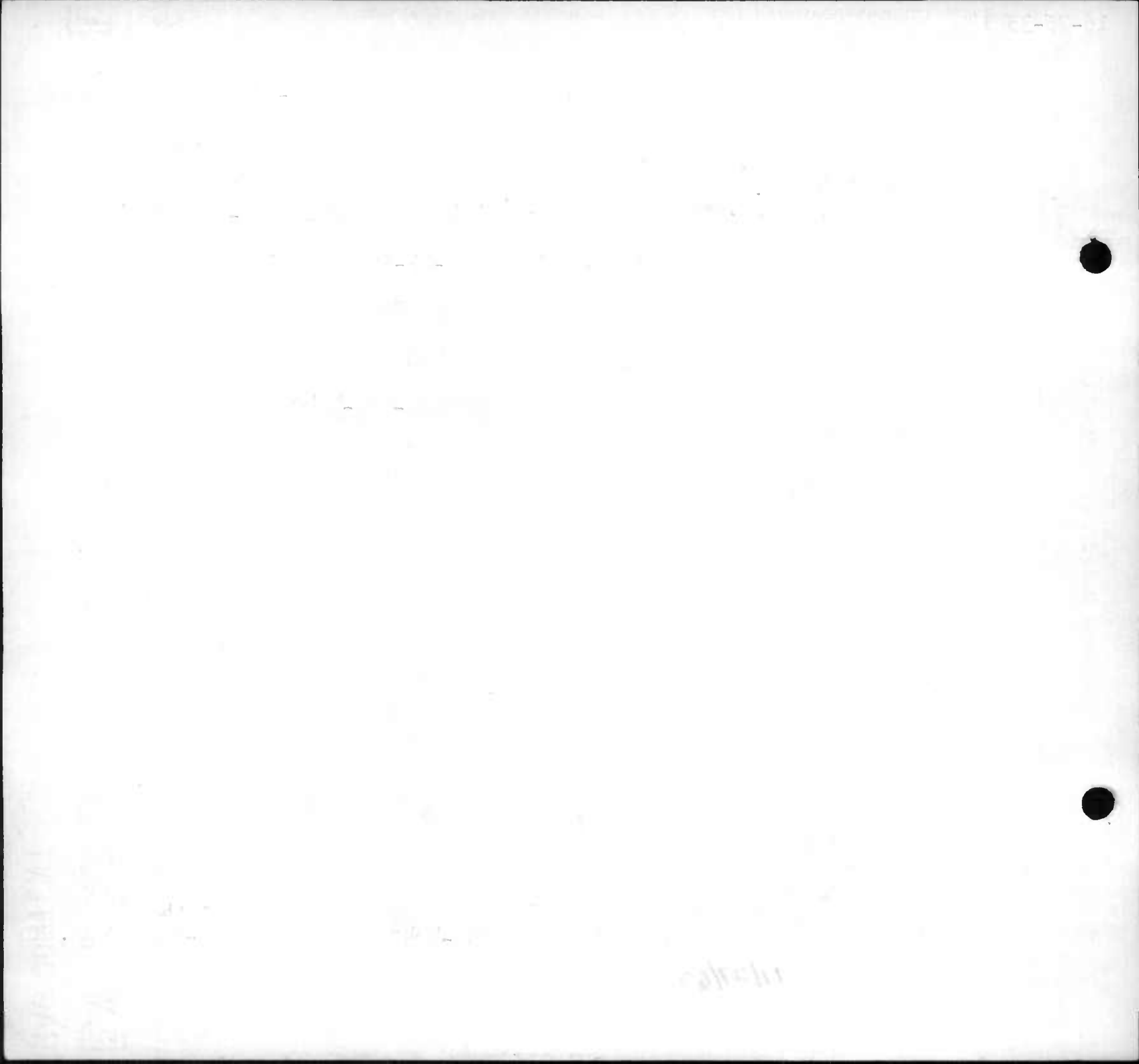




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>W-252</b>		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <b>WIGGINS OSCAR</b>		2. DATE AND HOUR OF DEATH <b>11-4-67 3:00 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224</b>		C. CITY OR TOWN (If outside city limits, give RURAL and give township) <b>BALTIMORE 26-12</b>	
D. STREET ADDRESS (If rural, give location) <b>4940 EASTERN AVENUE- #21224</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>12-13-67 99</b>
9. AGE (In years last birthday)		10. AGE (In years last birthday)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN WIGGINS</b>		14. MOTHER'S MAIDEN NAME <b>AMANDA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>RECORDS-BCH-4940 EASTERN AVENUE</b>		ADDRESS	
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Cardiovascular Collapse</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Acute Cardiovascular Collapse</b> (B) <b>POSSIBLE Gram (-) Septic</b> (C)	
INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>2-6-53</b> to <b>11-4-67</b> , that (I) (we) last saw the deceased alive on <b>11-4-67</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>P. Desmond</b>		23B. DATE SIGNED <b>11-4-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>P. Desmond</b>		23D. ADDRESS <b>21224 BCH-4940 EASTERN AVENUE-BALTIMORE, MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>11/27/67</b>	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>NOV 30 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR		ADDRESS	
<b>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</b>			



67 11479

BALTIMORE CITY HEALTH DEPARTMENT

67 11479

BIRTH NO.

M.E. CASE NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

## 1. NAME OF DECEASED

(Type or Print)

GEORGE I. HOFFMAN

## 2. DATE AND HOUR PRONOUNCED DEAD

November 4, 1967

9:01 A.M.

## 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

10 E. Pratt St.

## 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

## C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

## D. STREET ADDRESS (If rural, give location)

10 E. Pratt St.

## 5. SEX

Male

## 6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

## 8. DATE OF BIRTH

9. AGE (In years  
last birthday)

90

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

## 10B. KIND OF BUSINESS OR INDUSTRY

## 11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

## 13. FATHER'S NAME

## 14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

## 17. INFORMANT

## ADDRESS

## 18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

## 19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

## 20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

## 21E. INJURY OCCURRED

## 21F. HOW DID INJURY OCCUR?

## 22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURECharles S. Springate, M.D.  
EXAMINER'S NAME (Type)CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
November 4, 196723A. BURIAL CREMATION,  
REMOVAL (Specify)

## 23B. DATE

11/28/67

## 23C. NAME of CEMETERY or CREMATORY

## 23D. LOCATION (City, town, or county) (State)

## 24A. DATE REC'D BY HEALTH DEPT.

## 24B. NAME OF REGISTRAR

## 24C. FUNERAL DIRECTOR

## ADDRESS

NOV 30 1967

Robert E. Jenkins

MORTUARY SERVICE - BCHD

WILEY PAPER

WILEY PAPER

WILEY PAPER

11/24/11

1  
S-536

67 11480 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11480

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LEROY SCHNEIDER

2. DATE AND HOUR PRONOUNCED DEAD

November 8, 1967 7:55 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Maryland General Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

717 Lyndhurst Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Cirrhosis of the liver  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

11/28/67

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

NOV 30 1967 Robert E. Farley, M.D.

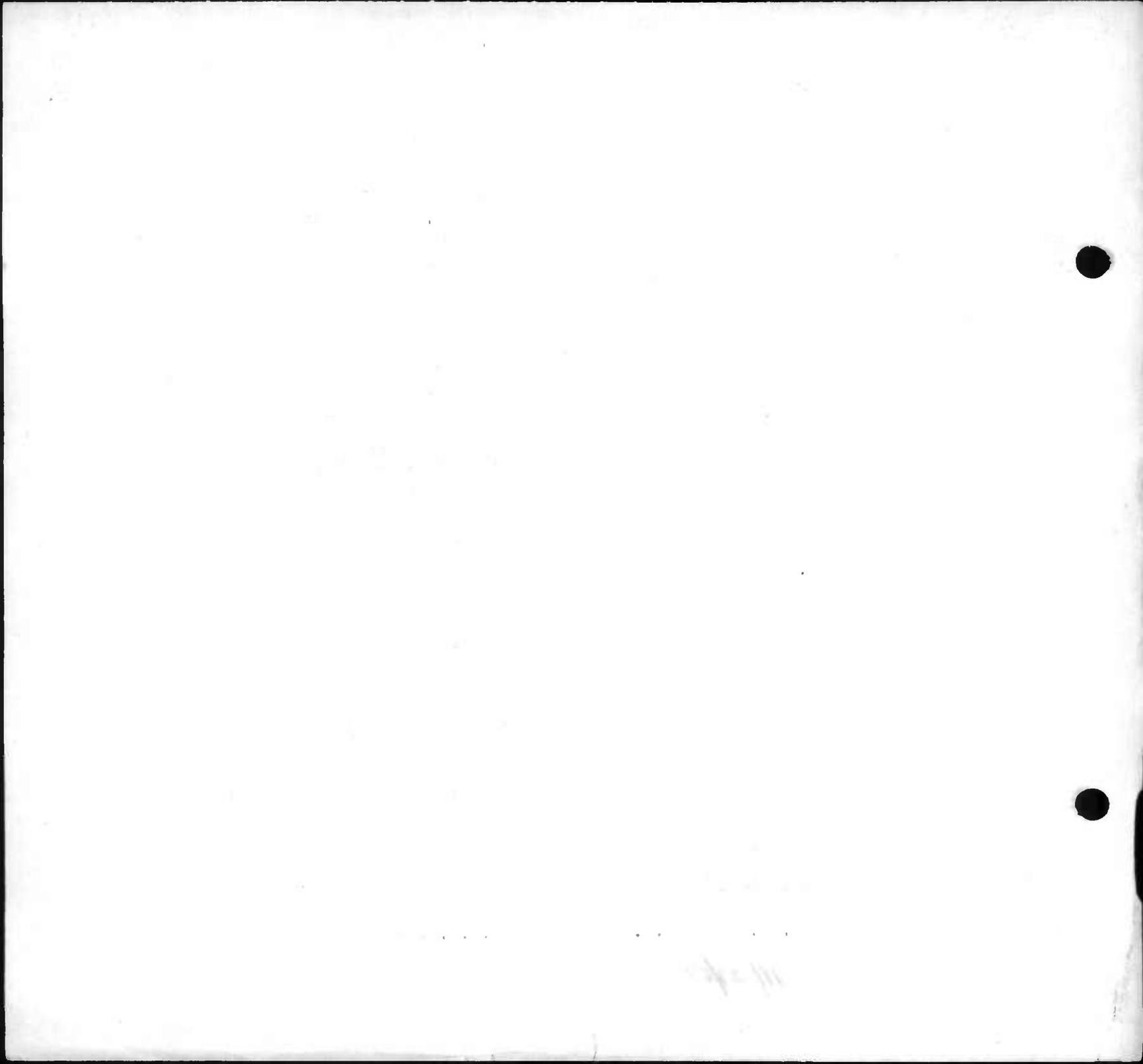
ANATOMY BOARD November 8, 1967  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCHD

Calvin

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

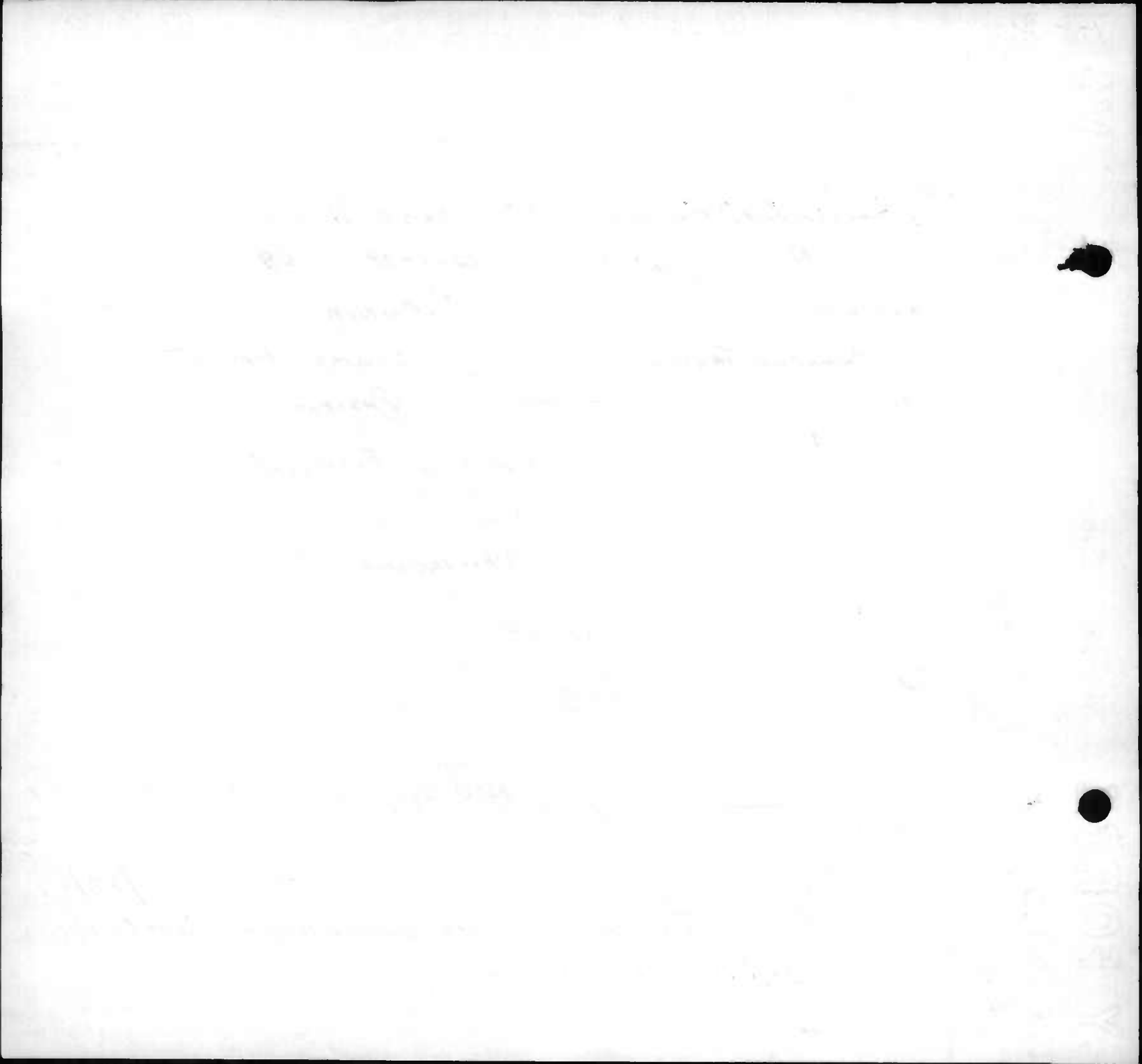
67 11481		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11481	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		Tom Adams		11/14/67 12:40 p. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  43 SOUTH BALTIMORE GENERAL HOSPITAL		A. STATE Maryland			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 200 W. Camden Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	Colored	Single	8/3/12	55	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Mose Allen			14. MOTHER'S MAIDEN NAME Rosalie Brown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
18. 502.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Respiratory Arrest DUE TO (B) Chronic Bronchitis & Emphysema DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 11/7/67 to 11/14/67 that (X) (we) lost saw the deceased alive on 11/14/67 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE D. M. Wood, M.D.				23B. DATE SIGNED 11/21/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS S.B.G.H. - 1213 Light Street	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 11/27/67		24C. NAME OF CEMETERY or CREMATORY	
25A. DATE REC'D BY HEALTH DEPT. NOV 30 1967		25B. NAME OF REGISTRAR R. E. E. Johnson		25C. FUNERAL DIRECTOR MORTUARY SERVICE	
				ADDRESS BCHD	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11482		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11482	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
LOUISE HACKETT		11/28/67 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
UNIVERSITY HOSPITAL BALTIMORE, MARYLAND		MARYLAND BALTIMORE			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
F		N		W	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Retired				12-1-98	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
CHARLIE TAYLOR		LOUISE HACKETT		68	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				PATIENT	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) VENTRICULAR FIBRILLATION		45 min +	
ANTECEDENT CAUSES		(B) MYOCARDIAL INFARCTION		3 days +	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Atherosclerotic C. V. D.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		NOTE			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from NOV 26, 1967 to NOV 28, 1967, that (I) (we) last saw the deceased alive on NOV 28, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
JOHN F. ROGERS				11/28/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JOHN F. ROGERS		UNIVERSITY HOSPITAL - DEPT OF MEDICINE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/2/67		Mt Auburn Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS			
Baltimore Maryland		Adolphus Halstead 1206 W North Ave			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
NOV 30 1967		Adolphus Halstead		1206 W North Ave	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 11483

BIRTH NO.

M.E. CASE NO.

## 1. NAME OF DECEASED

(Type or Print)

John

Albert (Kane) Keene

## 2. DATE AND HOUR PRONOUNCED DEAD

November 26, 1967

10:26 A. M.

## 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

CERTIFICATE AMENDED  
University Hospital

## 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

## C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

## D. STREET ADDRESS (If rural, give location)

634 Dover Street

## 5. SEX

Male

## 6. RACE

Negro

## 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Widowed

## 8. DATE OF BIRTH

7/14/08

## 9. AGE (In years last birthday)

59

## 10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

## 10B. KIND OF BUSINESS OR INDUSTRY

## 11. BIRTHPLACE (State or foreign country)

Maryland

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

John Keene

## 14. MOTHER'S MAIDEN NAME

Augusta Travers

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown; if yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

218-03-5505

## 17. INFORMANT

## ADDRESS

~~Walter M. Kane, 4115 Roland View~~  
~~Samuel H. Kane, 1024 W. Barre St.~~

1B. E 812.4

## CAUSE OF DEATH

## INTERVAL BETWEEN ONSET AND DEATH

## DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Injuries Complicated By  
XXXXXX Bronchopneumonia

## II ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

## 19A. DATE OF OPERATION

2

## 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

## 20A. AUTOPSY? (Yes or No)

Yes

## 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

## 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

## 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

## 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

600 Block of Portland Street

## 21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) m.  
11/17/67 5:40 P.

## 21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

## 21F. HOW DID INJURY OCCUR?

Pedestrian struck by car

## 22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

11/27/67

## 23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

## 23B. DATE

11/30/67

## 23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn

## 23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

## 24A. DATE REC'D BY HEALTH DEPT.

NOV 30 1967

## 24B. NAME OF REGISTRAR

Robert E. Fairbank

## 24C. FUNERAL DIRECTOR

## ADDRESS

Charles A. Rice 661 W. Barre St.

N 869.2

6/5/68 - Correction form from  
funeral director.

*Be.*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 11484</u>
BIRTH NO. <u>67 11484</u>		CERTIFICATE OF DEATH		
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <u>11-29-67</u> <u>4:53 A.</u> M.		
1. NAME OF DECEASED (Type or Print) <u>Viola Allen</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>38 University Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>21-01</u> D. STREET ADDRESS (If rural, give location) <u>903 Ridgely St.</u>		
5. SEX <u>Female</u>	6. RACE <u>N.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>6-9-1902</u>	9. AGE (In years last birthday) <u>65</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>James Haller 903 Ridgely St</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarction</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>6-7 h.</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>November 28</u> 19 <u>67</u> to <u>November 29</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov. 29</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>R. A. Przybylski</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11-29-67</u>
23C. PHYSICIAN'S NAME (Type) <u>Ruth Ann Przybylski</u>		23D. ADDRESS <u>M.D.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>12/4/67</u>	24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>NOV 30 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	25C. FUNERAL DIRECTOR <u>Charles A. Rice 661 W. Barnes</u>	

Brain 10/14/12  
Ruth Ann P. 12/18/12  
P. A. P. 12/18/12

Check to Mrs. P. A. P.

11-22-12  
Mar 12 12  
Number of 12

no

Antel Myocard  
Hypertension

James Miller P. A. P.

Western

no

Female M  
Married

8-9-1905 12

Myocard

12-1-1905 12

# FUNERAL DIRECTOR: IMPORTANT

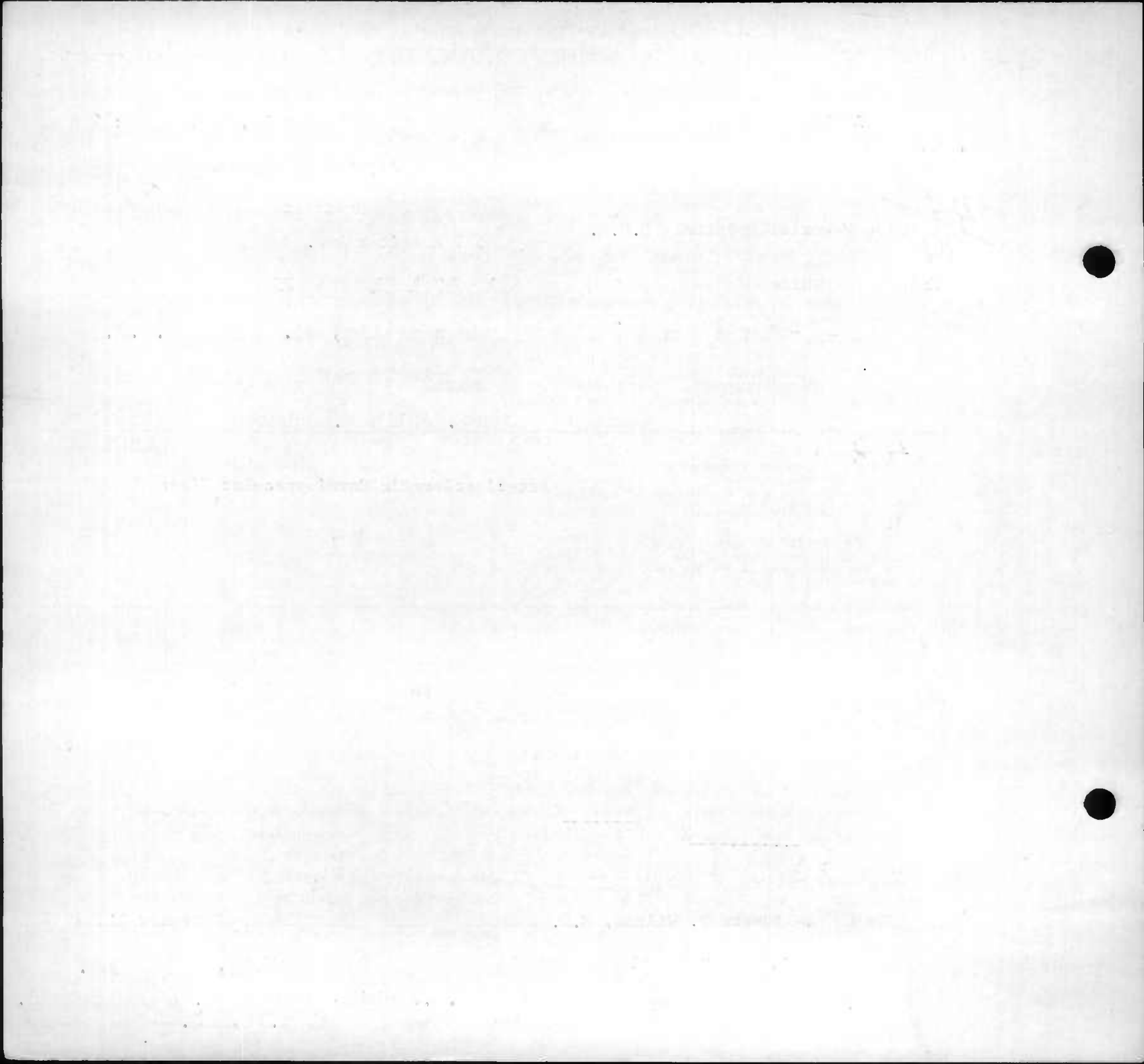
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-520		67 11485		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11485	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <i>ELiza beth S. Jones</i>				2. DATE AND HOUR OF DEATH <i>11-25-1967 6:10 p.m.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>OMEL chor Nursing Home</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>236 E. 25th. ST- 21218</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>June 27, 1882</i>	9. AGE (In years last birthday) <i>85</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>		11. BIRTHPLACE (State or foreign country) <i>EASTERN Shore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Alfred M. Davis</i>				14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>MRS. Ida Murphy - 236 E. 25th ST.</i>		ADDRESS	
18. <i>163 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>(1) "C.A. of the lung with Metastases"</i> <i>(2) (c) CVA &amp; L. Hemiplegia</i>				CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <i>10-28-1967</i> to <i>11-25-1967</i> , that (1) (we) lost saw the deceased alive on <i>11-25-1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Cesar Valle Cervero</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>11/28/1967</i>	
23C. PHYSICIAN'S NAME (Type) <i>CEsar VALLE CAVERO</i>				23D. ADDRESS <i>3629 Liberty Rd Randallstown</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/29/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Woodlawn</i>		24D. LOCATION (City, town, or county) (State) <i>Woodlawn, Balto. Co., Md.</i>	
25A. DATE REC'D. BY HEALTH DEPT. <i>NOV 30 1967</i>				25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>H.W. Jenkins &amp; Sons Co. 4905 York Road Balto., Md. 21212</i>	

Female white — a small female, 1882  
Melrose Park, New York  
234 E. 23rd St. New York  
Known  
Eastern Shore, Md. 1882  
No  
Mr. J. M. Davis  
Mr. J. M. Davis







1  
B-220

67 11487 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11487

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

CHRISTIAN

BACKHAUS

2. DATE AND HOUR PRONOUNCED DEAD

November 26, 1967

1:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Union Memorial Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6019 Old Harford Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

August 3, 1921

9. AGE (in years  
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

PARTS MANAGER

10B. KIND OF BUSINESS OR INDUSTRY

CHARLIE IRISH  
CABO. CO.

11. BIRTHPLACE (State or foreign country)

BALTO., Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ALBERT BACKHAUS

14. MOTHER'S MAIDEN NAME

MAMIE NAUMANN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

218-14-4851

17. INFORMANT WIFE

ADDRESS

MRS. MILDRED A. LOGUE

(SAME)

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/27/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

11-30-1967

23C. NAME OF CEMETERY or CREMATORY

PARKWOOD

23D. LOCATION

(City, town, or county)

(State)

TAYLOR AVE BALTO., Md.

24A. DATE REC'D BY HEALTH DEPT.

DEC 1 1967

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

ADDRESS

J. Walter Conklin 5444 BELAIR Rd.

ALBERT BACKMAN  
PARTS MANAGER  
GASOLINE TANK  
CARS CO.

MARIE  
BIRTH, MRS.  
MAMIE HANUMAN  
WIFE  
MRS. MILDRED ALBRECHT

1-10-1917  
M. J. HANUMAN

J. HANUMAN  
Taylor Ave. Bldg. 111

F-6501

67 11488

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

67 11488

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Mary A. Forney

2. DATE AND HOUR OF DEATH

Nov. 28, 1967.

6:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

312 South Stricker St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write P.O. and give town ship)

Baltimore

D. STREET ADDRESS (If rural, give location)

312 South Stricker St.

5. SEX

F

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 20, 1889.

9. AGE (In years  
last birthday)

78

If Under 1 Yr.

If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Sales Lady

10B. KIND OF BUSINESS OR INDUSTRY

Dept. Store

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Patrick Donohue

14. MOTHER'S MAIDEN NAME

Sabina Murphy

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) If yes, give war or dates of service

No

16. SOCIAL  
SECURITY NO.

213-20-5009A Frank B. Forney

ADDRESS

312 S. Stricker St.

18.

155.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Carcinoma Gall Bladder

6 mo.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Hypertensive CV Disease 25 yrs.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 1967 to November 1967.  
that (I) (we) last saw the deceased alive on 21 Nov 67 and that in (my) opinion death occurred on the date  
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

H. H. Baylus

M.D.

Attending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

29 Nov 67

23C. PHYSICIAN'S  
NAME (Type)

H. H. BAYLUS

M.D.

23D. ADDRESS

1600 WILKENS AVE

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12-2-67

24C. NAME OF CEMETERY or CREMATORY

New Cathedral Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

DEC 1

1967

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

ADDRESS

Walters Funeral Home Pratt & Stricker  
Sts.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1950

1950

1950

1950

1950

1950

1950

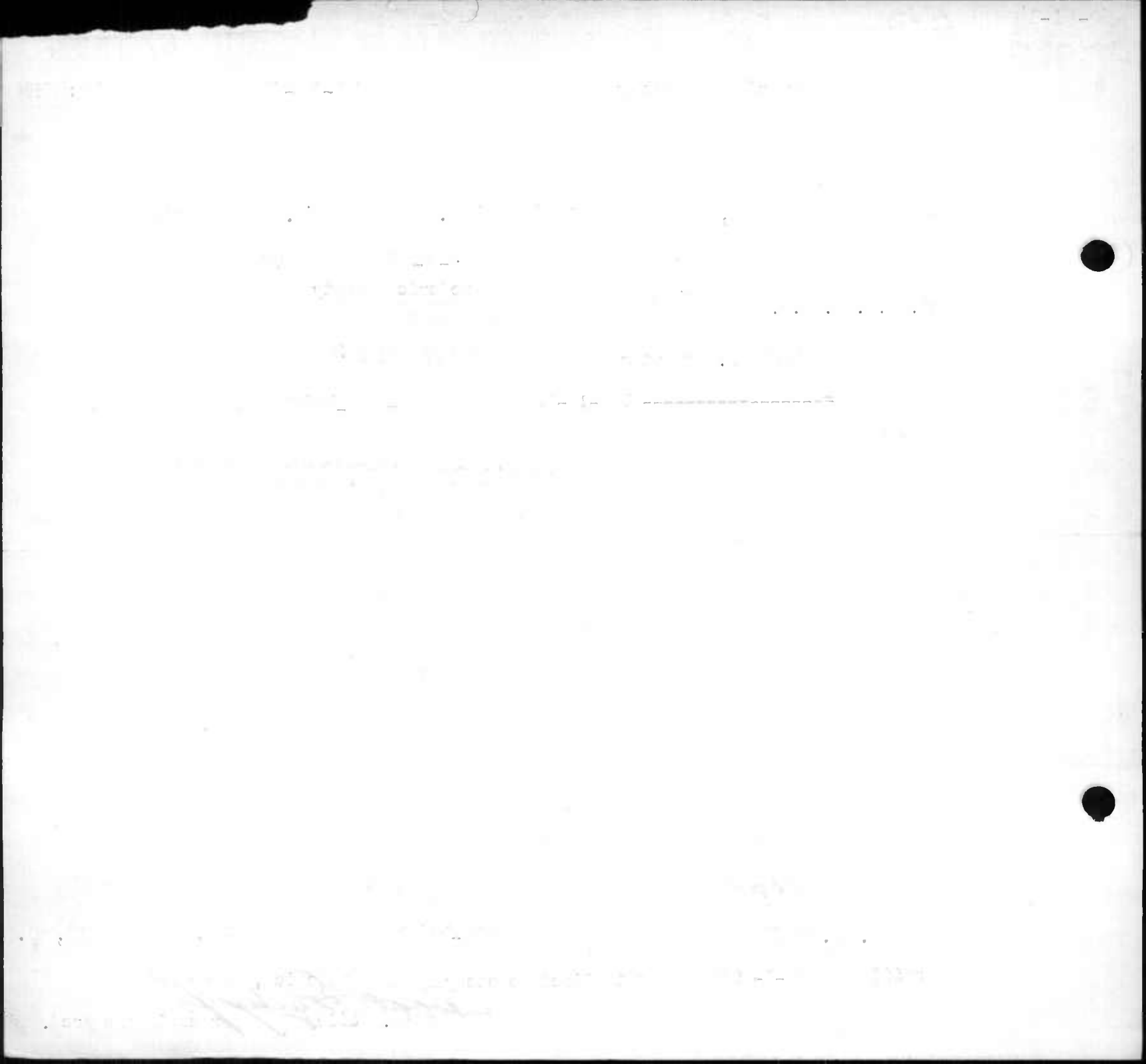
1950

50-51-14 1

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-263 BIRTH NO.		67 11489		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11489	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Francis Esworthy</b>				11-27-67 10:40PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BALTIMORE CITY HOSPITALS 4040 EASTERN AVENUE BALTIMORE, MARYLAND 21224</b>				A. STATE <b>MARYLAND</b> B. COUNTY			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>				D. STREET ADDRESS (If rural, give location) <b>6 N. CLINTON ST. #21224</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>6-9-88</b>	9. AGE (In years lost birthday) <b>79</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. B.&amp; O. R.R.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick County MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN A. Esworthy</b>				14. MOTHER'S MAIDEN NAME <b>SUSAN WILCOX</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-12-1900</b>		17. INFORMANT ADDRESS <b>RECORDS-BCH-4940 EASTERN AVENUE</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>SEPSIS FROM URINARY TRACT INFECTION ?</b>				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD, ILEUS</b>							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>ASCVD, ILEUS</b>							
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		22A. AUTOPSY? (Yes or No) <b>NO</b>		22B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from <b>11/3</b> 1967 to <b>11/27</b> 1967, that (X) (we) last saw the deceased alive on <b>11/27</b> 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>H. W. MEGER</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11/27/67</b>	
23C. PHYSICIAN'S NAME (Type) <b>H. W. MEGER</b>				23D. ADDRESS <b>BCH-4940 EASTERN AVENUE, BALTIMORE, MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-1-1967</b>		24C. NAME of CEMETERY or CREMATORY <b>Mount Olivet Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 1 1967</b>		25B. NAME OF REGISTRAR <b>Robert E. Dailey</b>		25C. FUNERAL DIRECTOR'S ADDRESS <b>Robert E. Dailey &amp; Son Funeral Home Fred. Md</b>			





F-400

67 11480 BALTIMORE CITY HEALTH DEPARTMENT

67 11480

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>TERESA/ Teresa M. FEELEY</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>November 27, 1967 5:50 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>St. Agnes Hospital (DOA)</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1716 Park Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>9/9/95</b>	9. AGE (In years last birthday) <b>72</b>	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Presser</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>m Joseph Steineman</b>				14. MOTHER'S MAIDEN NAME <b>Adelaide Zentgraf</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-16-8919</b>		17. INFORMANT ADDRESS <b>Leo S. Feeley, 1716 Park Ave., 21227</b>			
18. CAUSE OF DEATH <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>11/28/67</b>							
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>11/30/67</b>		23C. NAME of CEMETERY or CREMATORY <b>Morraine Park Cemetery</b>		23D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>DEC 1 1967</b>		24B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		24C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>			

WALLACE H. HOBBS

WALLACE H. HOBBS



R-240

67 11491

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

67 11491

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)EDWARD R. RUCKLE  
EDWARD RUCKLE

2. DATE AND HOUR OF DEATH

11/28 1967 3:25 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location) 21223  
2627 HAVER STREET

5. SEX

MALE

6. RACE

W.H.

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)  
MARRIED

8. DATE OF BIRTH 10

12-27-11

9. AGE (In years  
lost birthday)

5/5 56

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

PLUMBER

10B. KIND OF BUSINESS OR INDUSTRY

CONSTRUCTION

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Ruckle

Thomas L. RUCKLE

14. MOTHER'S MAIDEN NAME

Guintie

MARGARET

MCKENNA

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

228-05-7627

17. INFORMANT  
ADDRESSElsie M. Ruckle, 2627 Hafer St. 21223  
CHIAIRTI18. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, which  
rise to the above cause (A) slowing  
UNDERLYING CONDITION lost.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.A. MEDICAL EXAMINER'S CASE  
M.D.  
CHIEF OR ASST. MEDICAL EXAMINER  
NOTED

CAUSE OF DEATH

ACUTE MYOCARDIAL INFARCTION

INTERVAL BETWEEN  
ONSET AND DEATH

12 hours

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

11/21/67

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

BONE-TRANS PLANT

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
WorkNot While  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/27 1967 to 11/28 1967,  
that (I) (we) last saw the deceased alive on 11/28 1967 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

MAGNUS K. PETURSSON

M.D.

Attending  
Phys.Med.  
DirectorStaff  
Phys.

23B. DATE SIGNED

11/28 '67

23C. PHYSICIAN'S  
NAME (Type)

MAGNUS K. PETURSSON, M.D.

23D. ADDRESS

M.D.

THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12/1/67

24C. NAME OF CEMETERY or CREMATORY

New Cathedral Cemetery

24D. LOCATION

(City, town, or county)

Baltimore

Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 1 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

ADDRESS

Howard H. Hubbard, 4107 Wilkens Ave. 21229

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

11/28/51

11/28/51

MARYLAND

TRANSITION

UNION MEMORIAL HOSPITAL 2017 HANER STREET

MARY W. MARRIED 12-25-11 22

PLUMBER CONSTRUCTION MARYLAND

MARGARET McKEWANE

CHART

CHART

Acute Myocardial Infarction

MARYLAND TRANSITION OF CARE

11/28/51 BONE TRANS PLANT

11/28/51

11/28/51

11/28/51

11/28/51

11/28/51

MARYLAND TRANSITION OF CARE

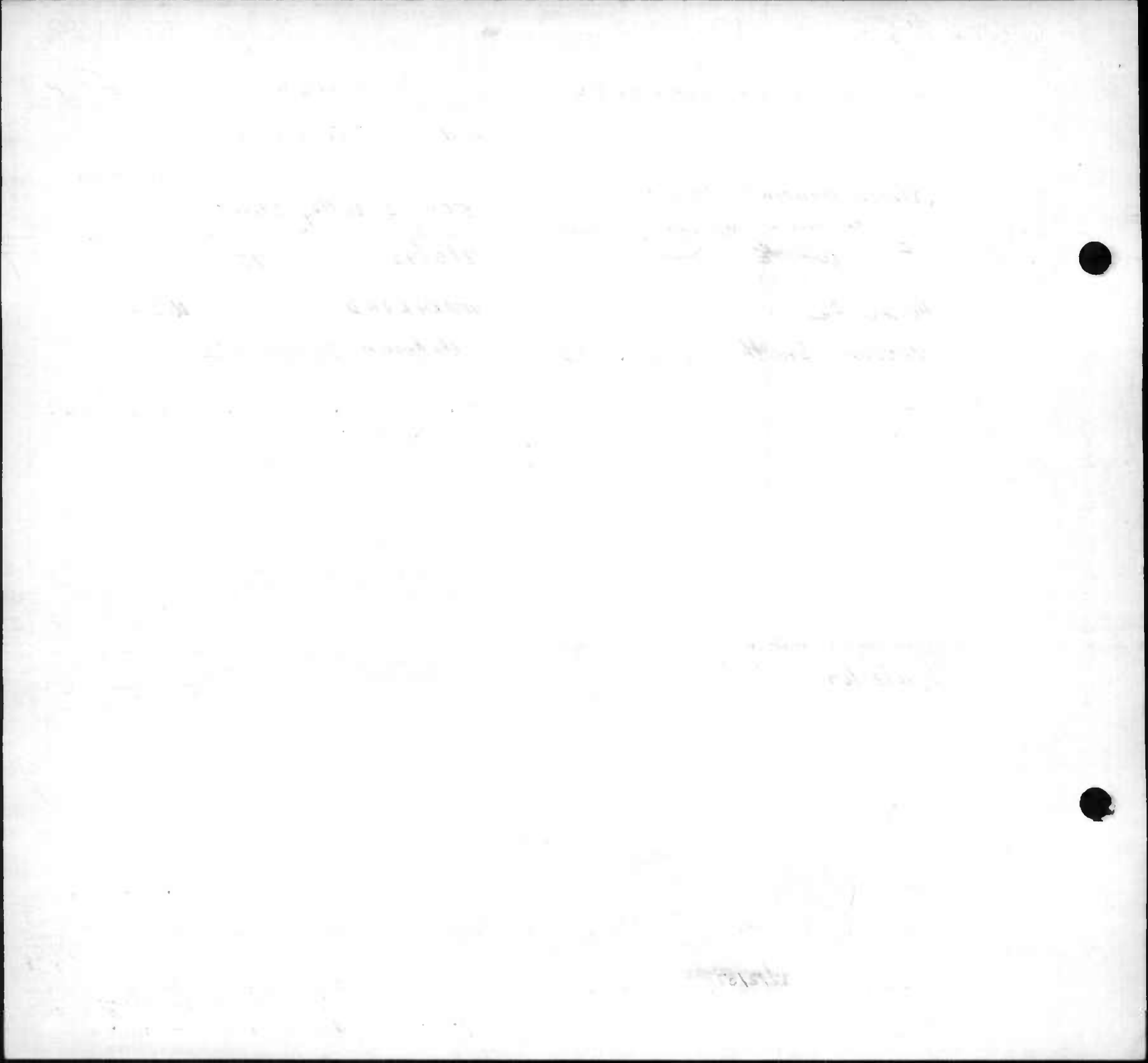
M. J. Johnson

MARYLAND TRANSITION OF CARE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11492		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 11492	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>EVA MAYETTA SCHWARTZ</u>		2. DATE AND HOUR OF DEATH <u>11/28/67</u> <u>6:20 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>44 Union Memorial Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>FREDERICK CO.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>60-11</u> D. STREET ADDRESS (If rural, give location) <u>504 A Valley Street</u>			
5. SEX <u>F</u>	6. RACE <u>WHITE</u>	7. <u>MARRIED</u> , NEVER MARRIED <u>WIDOWED</u> , DIVORCED (specify)	8. DATE OF BIRTH <u>8/5/92</u>	9. AGE (In years last birthday) <u>75</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles W. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Trail</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Quinton D. Thompson, McDonogh, Maryland</u>	
18. <u>578 XI</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Pneumonia</u> <u>Post resection of colon</u> (A) DUE TO (B) DUE TO (C) <u>J. Caudle</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>10/31/67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Divertericulitis</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 28</u> 19 <u>67</u> to <u>11/28</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/28</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Frank J. Gillean</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Nov. 28, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>FRANK J. Gillean</u>		23D. ADDRESS <u>Union Memorial Hos.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/2/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mount Olivet Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 1 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>M. R. Etchison &amp; Son, Frederick, Md.</u>			

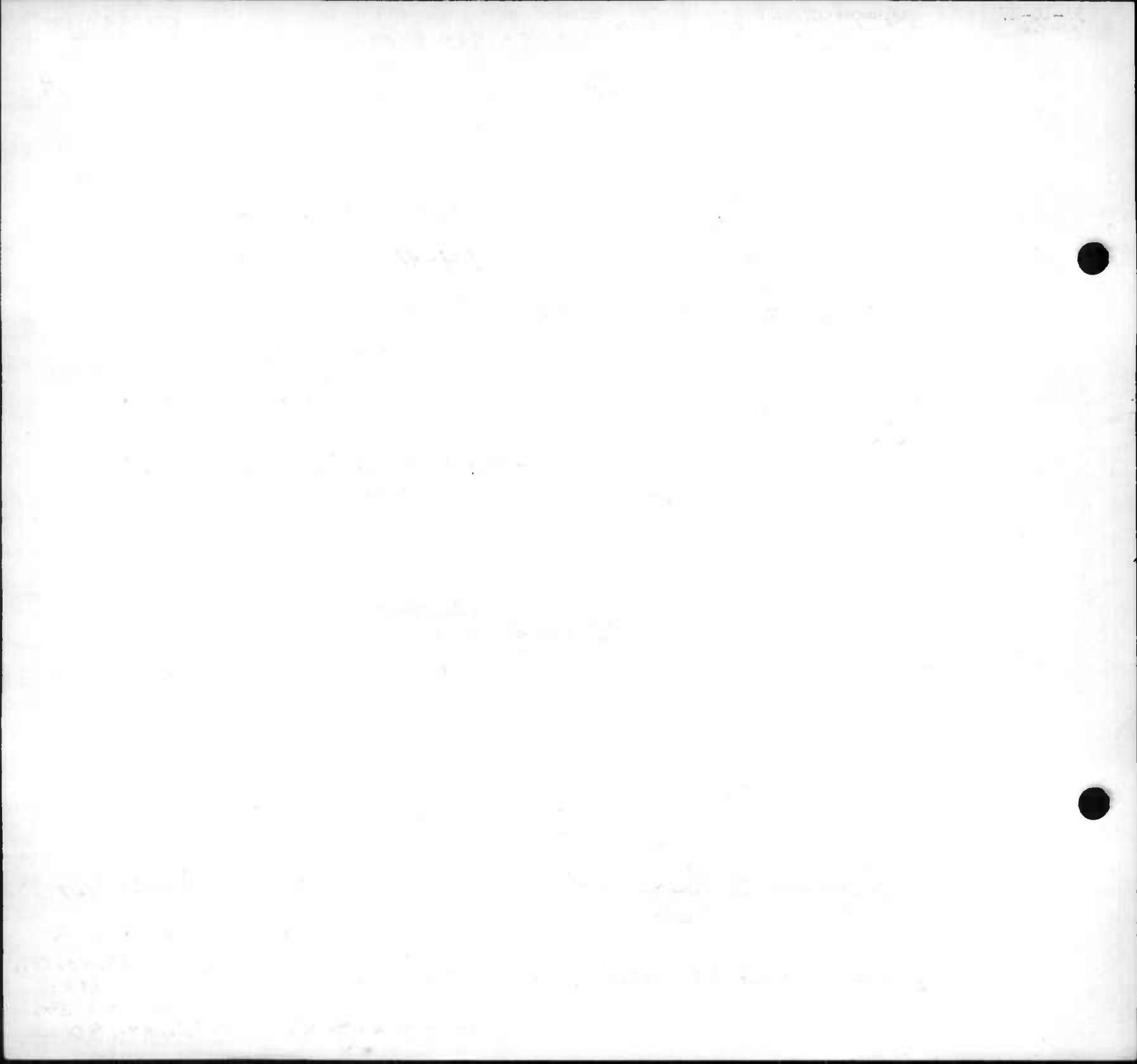


31-10-27 1  
IW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 11493	
BIRTH NO. 2-262				67 11493	
M.E. CASE NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) STELLA ZUKRZEWSKI STELLA G. ZUKRZEWSKI		2. DATE AND HOUR OF DEATH NOV. 23, 1967 7 <sup>30</sup> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4940 Eastern Avenue - 21224			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 1-4-91	9. AGE (In years last birthday) 76	10. Under 1 Yr. Months Days 11 Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY HOUSE WORK		11. BIRTHPLACE (State or foreign country) POLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME UNKNOWN			
14. MOTHER'S MAIDEN NAME UNKNOWN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Anteriosclerotic cerebrovascular disease (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 10 years		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Anteriosclerotic cardio- peripheral-vascular disease		21. INTERVAL BETWEEN ONSET AND DEATH 7/10 years			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/20 1961 to 11/23 1967. that (I) (we) last saw the deceased alive on 11/22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Benjamin Lechner, MD		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Nov 23, 1967	
23C. PHYSICIAN'S NAME (Type) BENJAMIN LECHNER		23D. ADDRESS Baltimore City Hospitals M.D. 4940 Eastern Avenue, Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 11-28-67		24C. NAME OF CEMETERY or CREMATORY HOLY ROSARY CEM	
24D. LOCATION 7800 GERMAN HILL RD.		BALTO. CO., MD.			
25A. DATE REC'D BY HEALTH DEPT. DEC 1 1967		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Charles L. Geiler	
ADDRESS 901 S. CONKLING ST. BALTO., MD.					





K-5231

67 11494

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 67 11494

BIRTH NO.

M.E. CASE NO.

KINSTLER

1. NAME OF DECEASED

(Type or Print)

Mrs Anna Kinstler

2. DATE AND HOUR OF DEATH

11-28-67 6:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, give RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1538 Charlotte Ave

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

2/18/85

9. AGE (In years  
last birthday)

82

If Under 1 Yr.

Months

Days

Hours

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Otto Trischman

14. MOTHER'S MAIDEN NAME

PAULINA SCHEFFLER

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

216-32-9714

17. INFORMANT

(Nephew) Frederick C. Trischman  
7918 Langdon Lane

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoporosis, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Cerebrovascular Accident  
DUE TOINTERVAL BETWEEN  
ONSET AND DEATH

3 days

(B)  
DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
WorkNot While  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-25 19 67 to 11-28 19 67,  
that (I) (we) last saw the deceased alive on 11-28 19 67 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

William L. Boddie

M.D.

Attending  
Phys.Med.  
DirectorStaff  
Phys.

23B. DATE SIGNED

11-28-67

23C. PHYSICIAN'S  
NAME (Type)

WILLIAM L. BODDIE

23D. ADDRESS

M.D.

Maryland General Hospital

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

12/1/67

24C. NAME OF CEMETERY OR CREMATORY

SCHWARTZ CEM

24D. LOCATION

(City, town, or county)

(State)

BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.

DEC 2 1967

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

J.G. CONNELLY SONS

ADDRESS

300 MACE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1875

1876

1877

1878

1879

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

67 11495

BIRTH NO.

67 11495

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Cox, Frederick H.

2. DATE AND HOUR OF DEATH

November 28, 1967 11:15 PM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

35 Church Home & Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1259 Riverside Ave.

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

8/26/05

9. AGE (in years last birthday)

62

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Receiving Clerk

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Alexander Cox

14. MOTHER'S MAIDEN NAME

Susan

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

215-18-7785

17. INFORMANT

Regina Cox

ADDRESS

1259 Riverside Ave.

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Acute Myocardial Infarction - 2 week

(B) DUE TO

Arteriosclerotic Cardiovascular Disease

(C)

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/15/67 to 11/28/67, that (I) (we) last saw the deceased alive on 11/28/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

[Signature]

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

11/28/67

23C. PHYSICIAN'S NAME (Type)

NEVITA L. SUAREZ

23D. ADDRESS

M.D.

Church Home & Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-2-67

24C. NAME OF CEMETERY or CREMATORY

New Cathedral Cemetery

24D. LOCATION

(City, town, or county)

(State)

4300 Old Frederick Road, Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 1 1967

25B. NAME OF REGISTRAR

Robert E. [Signature]

25C. FUNERAL DIRECTOR

Flynn & Fleming, 1422 Light St.

ADDRESS

1969 January 2nd

8/20/02

Handwritten signature

Handwritten signature

Handwritten signature

Handwritten notes and signatures at the bottom left.

Handwritten notes at the top right.



Handwritten signature

11/24 11/12/02 11/24

Handwritten signature

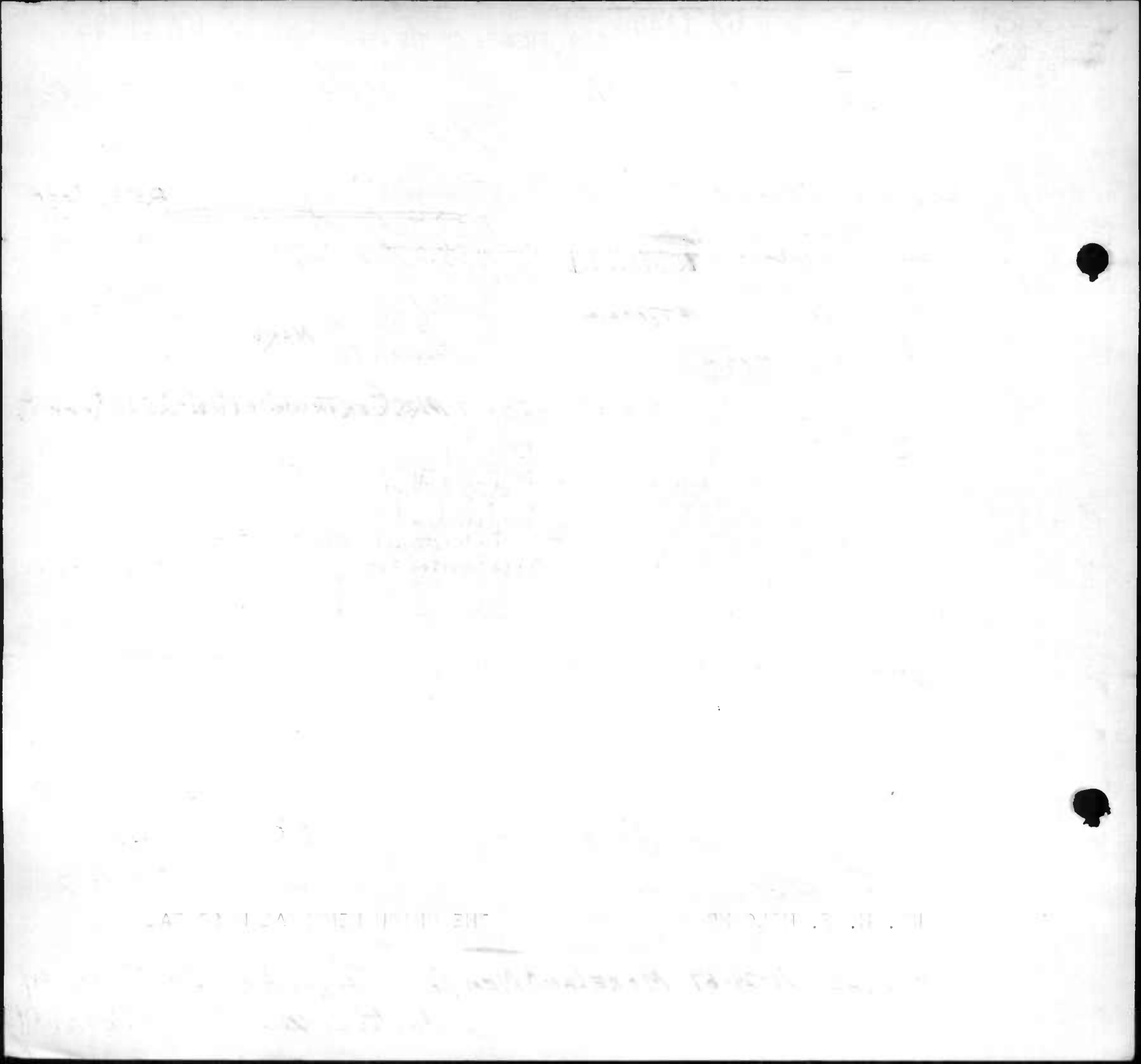
Handwritten signature

Handwritten notes and signatures at the bottom left.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11496 BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 11496	
BIRTH NO.				M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <i>Jay Mable M.</i>			2. DATE AND HOUR OF DEATH <i>11/26/67 1:20 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		
			D. STREET ADDRESS (If rural, give location) <i>1250 E. North Ave. 2533 Rebb ST.</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>2/24/92</i>	9. AGE (In years last birthday) <i>75</i>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>ATTORNEY</i>		
11. BIRTHPLACE (State or foreign country) <i>MD.</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Emil Herge</i>			14. MOTHER'S MAIDEN NAME <i>MARY Wilson</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>218-32-9256-T</i>		17. INFORMANT <i>MRS. GERTRUDE SEFTON</i>
			ADDRESS <i>2533 Rebb ST.</i>		
18. <i>570.5 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Bronchopneumonia</i> DUE TO <i>aspiration</i> (B) <i>Dehydration</i> DUE TO <i>intestinal obstruction</i> (C) <i>malnutrition</i>  INTERVAL BETWEEN ONSET AND DEATH <i>Dr. Yen</i>		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) <i>21C. WHERE DID INJURY OCCUR?</i>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>11/8/67</i> to <i>11/26/67</i> , that (1) (we) last saw the deceased alive on <i>11/26/67</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>H. F. Holcomb</i>				23B. DATE SIGNED <i>11/26/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. H. F. HOLCOMB</i>				23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>11-29-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>MORELAND MEM. PK</i>	
24D. LOCATION (City, town, or county) (State) <i>TAYLOR AVE BALTE. CO. MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 1 1967</i>			
25B. NAME OF REGISTRAR <i>Robert E. Fankhauser</i>		25C. FUNERAL DIRECTOR <i>J. Walter Conklin</i>			
ADDRESS <i>5444 BELAIR RD.</i>					



1  
R-120

67 11497 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 11497

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)  
OBELIA

BORDEAUX

REEVES

2. DATE AND HOUR PRONOUNCED DEAD

November 27, 1967

1:00 A.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

A.A.G.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore (Edgewater)

52-00

D. STREET ADDRESS (If rural, give location)

Route 2

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

widow

8. DATE OF BIRTH

Oct 6, 1895

9. AGE (In years  
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Goldsboro, N.C.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

CHARLES EDWARD ORTON

14. MOTHER'S MAIDEN NAME

LUCRETIA LANCASTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

577-07-0064

17. INFORMANT

ADDRESS

Evangeline RICHARDSON - Davidsonville, Md

18. CAUSE OF DEATH

E 812.41

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Multiple Injuries  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRI-  
BUTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

South end South River Bridge,  
Edgewater, Maryland

21D. TIME OF INJURY (APPROX.)

11/26/67 5:54 P.

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE AT  
WORK

21F. HOW DID INJURY OCCUR?

Pedestrian struck by car

52-00

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/27/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11/30/67

23C. NAME OF CEMETERY or CREMATORY

All Hallows

23D. LOCATION

(City, town, or county)

Bridgesville, Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

DEC 1

1967

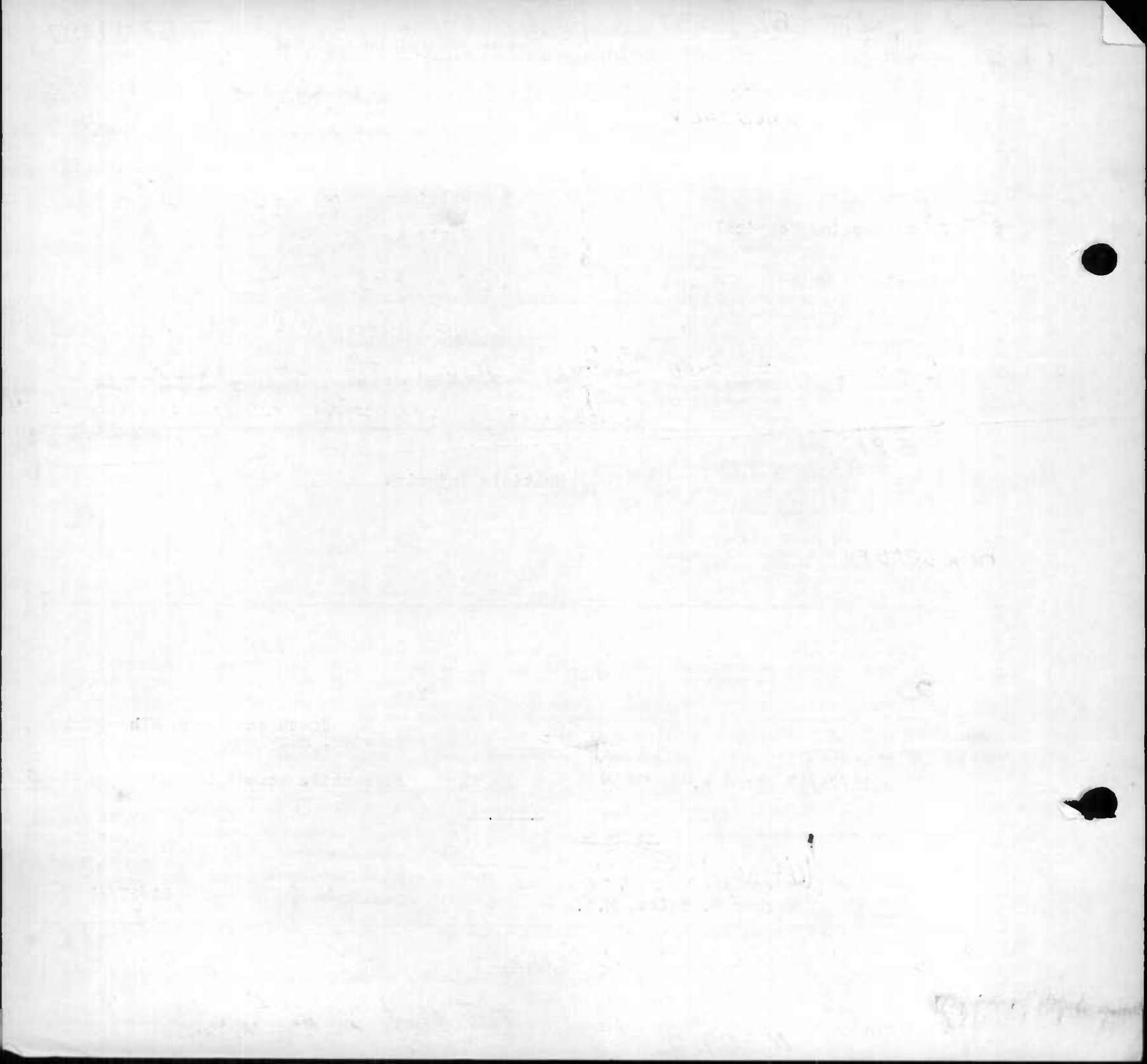
24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

T. A. Hordley Annapolis Md

ADDRESS





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>W-452</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>67 11498</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>RUBY AGNES WILLIAMS</b>			
2. DATE AND HOUR OF DEATH <b>11-29-67 12:05 A M.</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224</b>			
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CO.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE DUNDALK 53-00</b>			
D. STREET ADDRESS (If rural, give location) <b>2506 YORKWAY #21222</b>		5. SEX <b>FEMALE</b> 6. RACE <b>WHITE</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>SEPARATED</b>			
8. DATE OF BIRTH <b>8-12-22</b> 9. AGE (In years last birthday) <b>45</b>		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b> 10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>ANDREW</b>		14. MOTHER'S MAIDEN NAME <b>NELLIE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>35-22-0908</b>		17. INFORMANT <b>BALTIMORE, MD 21224</b>	
18. <b>176.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>GI bleeding</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Liver metastatic with Portal hypertension.</b>		(B) DUE TO		<b>2 months</b>	
		(C) <b>CARCINOMA OF VAGINA</b>		<b>4 months.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-29 1967</b> to <b>11-29 1967</b> , that (I) (we) last saw the deceased alive on <b>11-29- 19 67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>G. Alarcon MD</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>11-29-67</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. G. ALARCON</b>		23D. ADDRESS <b>21224 BCH-4940 EASTERN AVENUE, BALTIMORE, MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/2/67</b>		24C. NAME OF CEMETERY OR CREMATORY <b>HANDSSCHUMAKER</b>	
24D. LOCATION (City, town, or county) (State) <b>UPPER GLADE, W.VA.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 1 1967</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farley, MD</b>		25C. FUNERAL DIRECTOR <b>W. Brooks Bradley</b> ADDRESS <b>DUNDALK, MD.</b>			

SECRET

100

Continuation of message  
to the  
the  
the  
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2/1/50

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A-536

67 11499

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 11499

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

CHARLES

R.

ANDREASEN

2. DATE AND HOUR PRONOUNCED DEAD

November 27, 1967 10:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 1519 Lancaster St. (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1519 Lancaster Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

1900

9. AGE (In years  
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Balto. City Worker

11. BIRTHPLACE (State or foreign country)

Denmark

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Andreasen

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

219-10-3089

17. INFORMANT

1601 Gray Place  
A Betty Lee Gray : Balto., 21222, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/27/67

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

11-29-67

23C. NAME OF CEMETERY or CREMATORY

Mt. Carmel Cemetery

23D. LOCATION

(City, town, or county) (State)

5712 O'Donnell St. Balto., 24, Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

901 S. Conkling St.  
Balto., 21224, Md.

222  
The following is a list of the names of the persons who have been appointed to the various committees of the Board of Directors of the City of New York, for the year 1900.

Committee on the Administration of the City of New York  
Committee on the Finance of the City of New York  
Committee on the Police of the City of New York  
Committee on the Public Works of the City of New York  
Committee on the Sanitation of the City of New York  
Committee on the Streets of the City of New York  
Committee on the Taxation of the City of New York  
Committee on the Water Supply of the City of New York  
Committee on the Zoning of the City of New York

Adopted at a meeting of the Board of Directors, held on the 10th day of January, 1900.  
Attest:  
The Secretary of the Board of Directors.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 11500</u>	
BIRTH NO. <u>67 11500</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>EDWARD J. THORNBURG</u>		2. DATE AND HOUR OF DEATH <u>11/28/67</u> <u>1130 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>5934 Glen Oak Avenue</u> B. COUNTY <u>Baltimore, Maryland</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) <u>27-44</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>WINDSOR NURSING HOME</u> <u>3025 WINDSOR AVENUE</u>					
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Divorced</u>	8. DATE OF BIRTH <u>9/28/1900</u>	9. AGE (In years, lost birth) <u>67</u>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William THORNBURG</u>		14. MOTHER'S MAIDEN NAME <u>Mary Curran</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Helen Thornburg-6147 Parkway Dr.</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CORONARY THROMBOSIS</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/17/65</u> 19 to <u>11/28/67</u> 19 that (I) (we) last saw the deceased alive on <u>11/28/67</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u> M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>HORRIS JENNIFER</u> M.D.				23D. ADDRESS <u>5519 KENNISON AVENUE BALTIMORE MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>12/1/67</u>	24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 1 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Robert C. Altenburg Funeral Home, Inc. 6009 Harford Rd.</u>	

